

Case Number:	CM15-0090894		
Date Assigned:	05/15/2015	Date of Injury:	01/14/2013
Decision Date:	06/22/2015	UR Denial Date:	04/24/2015
Priority:	Standard	Application Received:	05/11/2015

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: New York, Tennessee
 Certification(s)/Specialty: Emergency Medicine

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is 50 year old male, who sustained an industrial injury on January 14, 2013. While lifting heavy objects at his job the injured worker felt a pop in the right shoulder. The injured worker has been treated for neck, back, right shoulder and abdominal complaints. The diagnoses have included low back pain, lumbar spine radiculopathy, lumbar disc protrusion, sacroiliac joint arthropathy, right shoulder impingement syndrome with labral tear, umbilical hernia, anxiety and depression. Treatment to date has included medications, radiological studies, physical therapy, psychiatric evaluation, physical therapy, transcutaneous electrical nerve stimulation unit, abdominal hernia repair and right shoulder surgery. Current documentation dated April 7, 2015 notes that the injured worker had tenderness over the spinous process of the lumbar spine, sacroiliac joints on the right side, facet joints and posterior superior iliac spine bilaterally. A straight leg raise test and Patrick's test were positive on the right side. Range of motion was noted to be decreased. The treating physician's plan of care included a request for the purchase of a motorized cold therapy unit and lumbar epidural steroid injections at right lumbar four-lumbar five and lumbar five-sacral one levels.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

1 Purchase of motorized cold therapy unit: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter, Continuous Flow Cryotherapy.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back - Lumbar and Thoracic, Cold/heat packs.

Decision rationale: MTUS does not address this topic. Cold/heat packs are recommended as an option for acute pain. At-home local applications of cold packs are recommended in first few days of acute complaint; thereafter, applications of heat packs or cold packs are recommended. Continuous low-level heat wrap therapy is superior to both acetaminophen and ibuprofen for treating low back pain. The evidence for the application of cold treatment to low-back pain is more limited than heat therapy, with only three poor quality studies located that support its use, but studies confirm that it may be a low risk low cost option. There is minimal evidence supporting the use of cold therapy, but heat therapy has been found to be helpful for pain reduction and return to normal function. While heat and cold packs are useful for low back pain, there is no recommendation that a Hot and Cold unit is necessary to supply the heat and cold applications to the affected area. Sufficient heat and cold can be applied with the use of hot packs, cold packs, or heating pad. The request for cold therapy unit is for post ESI care. ESI has not authorized There is no medical necessity for motorized cold unit. The request is not medically necessary and should not be authorized.

Lumbar steroid injection at right L4-L5 and L5-S1 levels: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections Page(s): 46.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Guidelines Page(s): 46.

Decision rationale: Epidural steroid injections are recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electro diagnostic testing. Epidural steroid injection can offer short term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program. There is little information on improved function. The American Academy of Neurology recently concluded that epidural steroid injections may lead to an improvement in radicular lumbosacral pain between 2 and 6 weeks following the injection, but they do not affect impairment of function or the need for surgery and do not provide long-term pain relief beyond 3 months, and there is insufficient evidence to make any recommendation for the use of epidural steroid injections to treat radicular cervical pain. In this case the diagnosis of radiculopathy is not supported by the documented physical examination and not corroborated by imaging studies. Criteria for ESI have not been met. The request is not medically necessary should not be authorized.