

<b>Case Number:</b>	CM13-0029043		
<b>Date Assigned:</b>	11/01/2013	<b>Date of Injury:</b>	11/24/2010
<b>Decision Date:</b>	01/07/2014	<b>UR Denial Date:</b>	09/10/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/19/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation has a subspecialty in Interventional Spine and is licensed to practice in California. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### CLINICAL CASE SUMMARY

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

26 year old female with injury from 11/24/10 suffers from chronic low back pain. UR letter from 9/10/13 reads that the MRI L-spine from 3/21/11 showed 3mm bulge at L5-S1 with facet arthropathy, moderate neural foraminal stenosis. Patient has had a number of spinal injections including SI joint injections, conservative care. The requests were denied due to lack of evidence in the guidelines for motorized unit for purchase. Review of the records include multiple copies of UR letters from 9/3, 9/4 and 9/10/13. [REDACTED] report from 6/5/13 shows severe low back pain which has been increasing in severity and intensity in recent weeks, 8/10 and up to 9/10. MRI from 3/21/11 is described as 3mm diffuse disc herniation at L5-1 with facet hypertrophy. Diagnosis includes lumbar sprain/strain, lumbago, multiple lumbar disc herniations, lumbar radiculitis/radiculopathy of the bilateral lower extremities, lumbar paraspinal muscle spasm, Sacroilitis bilaterally. Request was for a third ESI, and bilateral SI joint injections. There are multiple operative reports for ESI's and SI joint injections throughout 2013. [REDACTED] report from 11/7/12 report is reviewed which does not add much to the current request. 10/17/12 report is included and it appears that the patient is receiving ESI's and SI joint injections throughout 2012 as well. Unfortunately, other progress reports from 2013 are missing from 264 pages of medical reports.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**A hot and cold therapy pump:** 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)..

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation the Official Disability Guidelines (ODG), Spine Chapter..

**Decision rationale:** The California MTUS Guideline does not address cold/heat therapy units. The Official Disability Guidelines (ODG) has a detailed discussion and indicates that low grade heat is shown to be superior to other treatments including cold. There is no support for automated or motorized cold/heat treatment units for lumbar spine pain. Continuous flow cryotherapy has its place in treatments of post-operative management of shoulder and knee but not of the lumbar spine. Recommendation is for a denial of the request pump as there is no support from any of the guidelines.

**A hot and cold therapy pad:** 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)..

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Spine Chapter..

**Decision rationale:** The Official Disability Guidelines (ODG) has a detailed discussion and indicates that low grade heat is shown to be superior to other treatments including cold. There is no support for automated or motorized cold/heat treatment units for lumbar spine pain. Continuous flow cryotherapy has its place in treatments of post-operative management of shoulder and knee but not of the lumbar spine. Recommendation is for a denial of the requested pump as there is no support from any of the guidelines. The request does not specify what kind of heating or cold pads are being requested. Based on the other requests, I am under the assumption that these are pads that are used as part of the pump and/or motorized unit. While the guidelines see some support for low grade heat pads, motorized pumps are not supported. Recommendation is for denial of the requested pads.

**A motorized hot and 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)..

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Spine Chapter..

**Decision rationale:** The Official Disability Guidelines has a detailed discussion and indicates that low grade heat is shown to be superior to other treatments including cold. There is no support for automated or motorized cold/heat treatment units for lumbar spine pain. Continuous

flow cryotherapy has its place in treatments of post-operative management of shoulder and knee but not of the lumbar spine. Recommendation is for a denial of the requested motorized unit as there is no support from any of the guidelines.