

Case Number:	CM13-0031144		
Date Assigned:	12/04/2013	Date of Injury:	09/01/2010
Decision Date:	02/14/2014	UR Denial Date:	09/04/2013
Priority:	Standard	Application Received:	10/02/2013

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 & 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:

The patient is a 56-year-old female with a date of injury of 09/01/2010. UR dated 09/04/2013 makes reference to requesting PR dated 07/29/2013 by [REDACTED]. Unfortunately, that report was not provided for review. There are ten progress reports provided in the medical file, unfortunately not one is from requesting provider [REDACTED] but from four other treating physicians. None of the ten reports discusses cold therapy unit or lumbar traction unit. The utilization review letter from 9/4/13 references 7/29/13 treater's report that apparently reported "temporary" help with hot/cold therapy unit. Listed symptoms were constant neck and shoulder, as well as upper/lower back pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

Request for retrospective usage of a Cold Therapy Unit (rental or purchase): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation ODG-TWC Low Back Procedure Summary.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Cold/Heat Packs

Decision rationale: This patient presents with chronic bilateral shoulder, neck and upper and lower back pain from injury dated 2010. There is a request for cold therapy unit, which has helped the patient "temporarily" per report, 7/24/13, which was not included in the file reviewed. In reference to cold/heat, ACOEM page 300 states, "at-home local applications of heat or cold are as effective as those performed by therapists." For a more detailed discussion, ODG guidelines states "cold/heat packs states it is recommended as an option for acute pain. At-home local applications of cold packs in first few days of acute complaint; thereafter, applications of heat packs or cold packs". ODG also states "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. (French-Cochrane, 2006)" While uses of cold/heat treatments are reasonable, in this request, the exact nature of the therapy unit is not described. The description of "cold therapy unit" would imply something more than cold/heat gel packs, pads or patches that are commonly available. There are also some sophisticated automated cold/heat units that are not recommended per ODG guidelines. In addition, this patient appears to present with widespread pain of the spine that is not easily amenable to cold/heat applications. The referenced 7/24/13 report only seems to indicate "temporary" relief. Recommendation is for denial.

Request for retrospective usage of a Lumbar Traction Unit (rental or purchase): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation ODG-TWC Low Back Procedure Summary.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

Decision rationale: This patient presents with chronic bilateral shoulder, neck and upper and lower back pain from injury dated 2010. Treater is requesting a retrospective lumbar traction. ACOEM page 300 states the following regarding lumbar traction: "Traction has not been proved effective for lasting relief in treating low back pain. Because evidence is insufficient to support using vertebral axial decompression for treating low back injuries, it is not recommended." Recommendation is for denial.