

<b>Case Number:</b>	CM13-0039044		
<b>Date Assigned:</b>	12/18/2013	<b>Date of Injury:</b>	12/20/2011
<b>Decision Date:</b>	02/14/2014	<b>UR Denial Date:</b>	09/18/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Florida. 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 31-year-old male who reported an injury on 12/20/2011. The patient is status post laminectomy and neural decompression performed on 08/22/2013. The patient has undergone physical therapy for this back and has seen an a qualified medical evaluator (QME) or agreed medical evaluator (AME) exam physician on 09/26/2013. The patient was most recently seen on 12/04/2013 for continuing severe low back pain that radiates to his right lower extremity. The patient reports that his pain has worsened since he went back to work recently. The patient stated that he stopped physical therapy due to pain more than a month ago. He has been taking medication as prescribed. Under the physical examination, it noted that the paraspinal muscles of the lumbar spine were tender, spasms were present, and range of motion was restricted. Motor strength is grossly intact, sensation is reduced in the right L5 dermatomal distribution, and the straight leg raising test is positive on the right side with no sign of infection on the incision side.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**TEC system with Lumbar Wrap Cover times twenty one days/RFM times two: 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:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Cold/heat packs

**Decision rationale:** Regarding the request for a TEC system with lumbar wrap cover times twenty one days/RFM times two, according to California Medical Treatment Utilization Schedule (MTUS) and American College of Occupational and Environmental Medicine (ACOEM) it states that at home local applications of heat or cold are as effective as those performed by therapists. Initially, it states that at home applications of cold are recommended for the first few days of acute complaints; there after, applications of heat or cold can be alternated. Official Disability Guidelines further state that cold/heat packs are recommended as an option for acute pain. At home, local applications of cold packs in the first few days of acute complaint; thereafter, applications of heat packs or cold packs are recommended. In the case of this patient, he is now approximately six months postoperative and well into his healing phase. Because of the elapsed time from the patient's surgical procedure to the present date, the use of a cryotherapy unit would not be medically necessary. At this stage of healing and treating, the home application of heat or cold therapy is recommended for comfort measures. This can include ice packs, warm compresses/showers, etc. Regarding a lumbar wrap, under California Medical Treatment Utilization Schedule (MTUS) and American College of Occupational and Environmental Medicine (ACOEM) it states that lumbar support (corset) is not recommended for the treatment of low back disorders. Therefore, in regards to the request for a TEC system with lumbar wrap cover times twenty one days/RFM times two, the medical necessity for the system cannot be established at this time. As such, the requested service is non-certified.