

Case Number:	CM13-0057116		
Date Assigned:	12/30/2013	Date of Injury:	12/01/2009
Decision Date:	05/15/2014	UR Denial Date:	11/11/2013
Priority:	Standard	Application Received:	11/25/2013

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. The expert reviewer is Board Certified in Occupational Medicine 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 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/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 41 year old male who was injured on 12/01/2009. The patient was in a motor vehicle accident when his vehicle struck another vehicle; pain to the neck, with numbness in the left upper extremity. Prior treatment history has included (list prior treatments). The patient underwent left sided L5-S1 hemilaminotomy, partial medial facetectomy and neuroforaminotomy on 09/20/2012. An MRI of the lumbar spine dated 05/28/2013 revealed status post prior left hemilaminotomy at L5-S1; enhancing scar tissue is seen in the left lateral and anterolateral epidural space with perineural scar tissue encasing the left S1 nerve root; appearance of 2 mm central paracentral disc osteophyte complex with right paracentral lateral component more prominent is seen at L5-S1. There is no definite evidence of recurrent disc herniation at L5-S1. There is no abnormal enhancement of intrathecal space or conus. An MRI of the lumbar spine dated 10/25/2013 revealed L5-S1 post-surgical findings status post left laminotomy. There is enhancing fibroglandular tissue in the lateral recess and there are lateral disc-osteophytes. There is no thecal sac or nerve root compression. Electrodiagnostic study performed on 10/17/2013 revealed a normal study. A CT of the lumbar spine without contrast performed on 12/01/2009 revealed no evidence of fracture or malalignment; disc protrusion that is slightly worse paracentrally on the right at L5-S1; diffuse annular bulge at L4-5. A Primary Treating Physician's Report dated 08/28/2013 indicated the patient presents with increasing pain to the low back, with numbness in the left lower extremity; soreness in the left elbow and left wrist. The patient is diagnosed with 1) Chronic cervical strain without evidence of cervical disc or intraspinal injury; 2) Tendinitis and impingement of the left shoulder; 3) Left elbow and wrist strain; 4) History of sexual dysfunction secondary to back pain and depression; 5) Chronic sprain/strain of the thoracolumbosacral spine and associated musculoligamentous structures with worsening lumbar disc protrusion; 6) Acute left lumbar radiculopathy with cauda equina

syndrome and/or S1 type radiculopathy; 7) Status post chronic left-sided L5-S1 disc herniation with nerve root impingement and radiculopathy, status post surgery.

IMR ISSUES, DECISIONS AND RATIONALES

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

Thermocool hot and cold contrast therapy with compression: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 555-556.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 44. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Cold/heat packs

Decision rationale: According to the Official Disability Guidelines, heat and cold packs are 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 may be indicated. Short term rental of a continuous cryotherapy device may be recommended as an option after surgery, but not for nonsurgical treatment. The device is not supported by the evidence-based guidelines. There is inadequate clinical evidence to substantiate that circulating hot-cold delivery system device is more efficacious than standard ice/cold and hot packs. The references state mechanical circulating units with pumps have not been proven to be more effective than passive hot and cold therapy. Simple at home applications of heat and cold can suffice for delivery of heat or cold therapy. The medical necessity of Thermocool hot and cold contrast therapy with compression is not established. The request is non-certified.