

Case Number:	CM14-0000057		
Date Assigned:	05/07/2014	Date of Injury:	06/26/2001
Decision Date:	12/31/2014	UR Denial Date:	11/25/2013
Priority:	Standard	Application Received:	12/31/2013

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 injured worker is a male with date of injury 6/26/2001. Primary treating physician's progress report dated 9/13/2013 indicates that the injured worker continues to have pain in his lower back which is mostly axial in nature. He rates his pain in his left knee as 5/10, and is aggravated with any type of bending, twisting, and turning. His pain is facet generated having undergone a very successful ablation at L3, L4 and L5 on 4/23/2012 which provided seven months of relief with improvement in mobility and activity tolerance. He continues to complain of pain in his left knee, having significant degenerative osteoarthritis. The pain is aggravated with weight bearing and affects his mobility. He rates his pain 5/10. He has been considered for total knee replacement, but the injured worker remains reluctant to undergo surgery. Examination of the lumbar spine reveals tenderness to palpation at the posterior musculature bilaterally, but mainly on the left side. He has increased muscle rigidity along the lumbar paraspinal muscles. There was also pain reproducible with facet loading noted on the lower lumbar spine. He has decreased range of motion. He is able to bring his fingertips to the level of his knees and extension was limited to 10 degrees. He has pain with lumbar extension. Straight leg raise in the modified sitting position is positive at about 45 degrees which cause mostly axial back pain bilaterally. He has decreased sensation along the left lateral thigh in comparison to the right. The left knee is positive for soft tissue swelling. He has decreased range of motion and lacks full extension of about 5 degrees and flexion to about 110 degrees, which has improved since his last visit. Diagnoses include 1) lumbar spine sprain/strain syndrome 2) left lower extremity radiculopathy 3) lumbar facet joint syndrome 4) status post L4-5 laminectomy/discectomy, 2000 5) left knee internal derangement 6) status post radiofrequency thermo coagulation procedure 12/13/2006 and 2/20/2008 7) medication induced gastritis 8) status post gastric bypass surgery, 4/29/2009.

IMR ISSUES, DECISIONS AND RATIONALES

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

DME Thermacool Hot/Cold Compression 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: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 155.

Decision rationale: The MTUS Guidelines recommend the self-administration of low-tech cryotherapies for the management of acute back pain, and that routine use of cryotherapies in health care provider offices or home use of a high-tech device for the treatment of LBP is not recommended. The injured worker has a chronic injury to his low back and knee, and is not in a post-surgical treatment period. Medical necessity for durable medical equipment providing cold/heat compression therapy has not been established. There is no evidence that the injured worker requires anything beyond low tech cold or hot compresses. The request for DME Thermacool Hot/Cold Compression Unit is determined to not be medically necessary.