

<b>Case Number:</b>	CM14-0011219		
<b>Date Assigned:</b>	02/21/2014	<b>Date of Injury:</b>	06/11/2006
<b>Decision Date:</b>	06/25/2014	<b>UR Denial Date:</b>	01/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/28/2014

### 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 Orthopedic Surgery 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:

This 43-year-old male sustained an industrial injury on 6/11/06. The injury occurred while he was lifting metal pizza pans in a forward bent position, with onset of mid- and low back pain. He underwent discectomy and laminectomy at L5/S1 on 9/13/06, and instrumented 360 degree fusion on 7/12/07. The 11/13/13 treating physician report cited subjective complaints of low back and radicular lower extremity pain, getting worse and increased anxiety and depression. Objective findings documented tenderness to palpation over the lumbar paraspinal musculature with spasms. The diagnosis was status post instrumented fusion 360-degree lumbar spine with residual pain and progression of back and leg pain, gastritis, exogenous obesity, and symptoms of anxiety and depression. The treatment plan requested authorization for caudal lumbar epidural steroid injection with procedure modification for pain purposes and pre-operative labs were ordered. The records indicate that the patient was scheduled for surgery on 12/14/13, with a request for post-surgical hot/cold unit. The 1/17/14 utilization review modified the 12/14/13 request for a post-surgical hot/cold unit for 6 weeks and certified 7-days use consistent with guidelines.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**THERMACOOLER SYSTEM (HOT, COLD AND COMPRESSION SYSTEM) E1399 AND THERMOCOOLER PAD/WRAP E0249 FOR 6 WEEKS: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308-310. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Cold/heat packs, and Knee and Leg chapter, compression garment.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back - Lumbar & Thoracic, Cold/heat packs

**Decision rationale:** Under consideration is a request for a post-operative hot/cold unit. The California MTUS is silent regarding cold therapy units. The Official Disability Guidelines (ODG) recommends cold/heat packs as an option for acute low back pain. In general, the ODG recommends continuous flow cryotherapy systems for up to seven days post-operative use. The 1/17/14 utilization review certified a 7-day rental of the requested unit, modified from a six week request. There is no compelling reason submitted to support the medical necessity of this unit beyond the 7-day certification. Therefore, the request for Thermacooler system (hot, cold and compression system) E1399 and Thermocooler pad/wrap E0249 for 6 weeks is not medically necessary.