

Case Number:	CM14-0012516		
Date Assigned:	02/21/2014	Date of Injury:	11/11/1994
Decision Date:	06/30/2014	UR Denial Date:	01/02/2014
Priority:	Standard	Application Received:	01/30/2014

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 Texas. 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 47-year-old female who reported an injury on 11/11/1994 secondary to an unknown mechanism of injury. The patient was evaluated on 12/20/2013 for reports of radiating low back pain to the left lower extremity. The exam noted decreased senses to the L2-3 area and a decreased Babinski's was noted, along with a positive femoral stretch. The exam further indicated a 30% loss of range of motion of the lumbar spine. Diagnoses include L2-3 disc herniation and segmental instability at L2-3. The treatment plan included an anterior lumbar decompression and instrumented fusion at L2-3. The request for authorization dated 12/23/2013 was found in the documentation provided. The rationale for the request was not found in the documentation provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

HOT/COLD THERAPY UNIT: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Non-MTUS Citation: Official Disability Guidelines (ODG)

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, Cold and Heat Packs

Decision rationale: The Official Disability Guidelines recommend cold and heat packs as an option for acute pain. However, in this case, there is no clinical evidence of the need for a continuous heat and cold therapy unit. Furthermore, the length of need for the request is not noted. The request for hot/cold therapy unit is not medically necessary and appropriate.