

Case Number:	CM14-0014055		
Date Assigned:	03/14/2014	Date of Injury:	03/17/2010
Decision Date:	08/11/2014	UR Denial Date:	01/16/2014
Priority:	Standard	Application Received:	02/04/2014

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 Physical Medicine & Rehabilitation 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 is a 55-year-old male with a 3/17/10 date of injury. The mechanism of injury was not noted. In a 12/30/13 progress note, the patient continued to be symptomatic with regard to the lower back. The pain was over the left paraspinal and left sacroiliac joint with spasm. The patient stated that doing chores around the house aggravated the pain. The patient uses a lumbar belt to help her to do stuff around the home. The patient also had difficulty with sleeping on one side versus the other due to the pain in the left side of the lumbar spine. Physical examination showed palpatory tenderness of the lumbar paraspinal on the left side that extended into the left sacroiliac joint and left buttock region. Straight leg raise test bilaterally was positive for pain in the lumbar spine with no leg pain. Diagnostic impression: Lumbar spondylosis from L1 through L5, Degenerative grade 1 anterolisthese of L5 on S1, Bilateral knee pain, likely osteoarthritis, Status post right knee surgery, Right hip pain, likely osteoarthritis. Treatment to date: medication management, activity modification, physical therapy. A UR decision dated 1/16/14 denied the request for ThermoCool Hot and Cold Contrast Therapy With Compression. There was no rationale provided by the requesting physician to support the necessity of the device over at home applications of hot/cold packs.

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: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Non-MTUS Official Disability Guidelines (ODG), Low Back, Cold/heat packs.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Aetna Clinical Policy Bulletin: Cryoanalgesia and Therapeutic Cold.

Decision rationale: CA MTUS and ODG do not specifically address this issue. Aetna considers the use of the Hot/Ice Machine and similar devices (e.g., the Hot/Ice Thermal Blanket, the TEC Thermoelectric Cooling System (an iceless cold compression device), the Vital Wear Cold/Hot Wrap, and the Vital Wrap) experimental and investigational for reducing pain and swelling after surgery or injury. Studies in the published literature have been poorly designed and have failed to show that the Hot/Ice Machine offers any benefit over standard cryotherapy with ice bags/packs; and there are no studies evaluating its use as a heat source. Guidelines recommend the use of cold/heat packs as an option for acute pain. In the reports reviewed, there is no documentation that the patient has tried using cold/heat packs for his pain. A specific rationale identifying why a hot and cold therapy unit would be required in this patient despite lack of guideline support was not identified. Therefore, the request for Thermocool hot and cold contrast therapy with compression is not medically necessary.