

<b>Case Number:</b>	CM14-0154048		
<b>Date Assigned:</b>	09/23/2014	<b>Date of Injury:</b>	03/03/2004
<b>Decision Date:</b>	10/29/2014	<b>UR Denial Date:</b>	09/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/22/2014

### 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 and Rehabilitation and is licensed to practice in Texas and Ohio. 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 55-year-old female who reported an injury on 03/03/2004. The mechanism of injury was noted as continuous trauma. Diagnoses included musculoligamentous sprain/strain to the cervical, thoracic, and lumbar spine; right sacroiliac joint sprain; and bilateral shoulder parascapular strain/tendinitis/impingement. Past treatments included a home exercise program, chiropractic manipulation, and medications. Pertinent diagnostic studies were not provided. Pertinent surgical history was not provided. The clinical note dated 09/03/2014 indicated the injured worker complained of pain in the low back radiating to the right lower extremity rated 8/10. The physical exam revealed decreased range of motion and tenderness to palpation of the cervical and lumbar spine, and positive sacroiliac stress test. Current medications were not provided. The treatment plan included Thermaphore moist heat pad QTY: 1. The rationale for the request was not provided. The Request for Authorization form was completed on 09/03/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Thermaphore moist heat pad QTY: 1.00:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Online ; Thermaphore moist heat pad QTY: 1.00

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Cold/heat packs

**Decision rationale:** The request for Thermaphore moist heat pad QTY: 1 is not medically necessary. The California MTUS/ACOEM Guidelines indicate that methods of symptom control for low back complaints include applications of heat or cold. The Official Disability Guidelines go on to state that cold/hot packs are recommended as an option for acute pain. The injured worker complained of low back pain radiating to the right lower extremity. As the injury reportedly occurred on 03/03/2004 and she is being treated for chronic pain, she has exceeded the acute phase of symptom relief. The Guidelines indicate that heat packs are recommended as an option for acute pain, therefore the request cannot be supported. Additionally, there is a lack of documentation to indicate the specific need for Thermaphore moist heat over traditional heat packs. Therefore, the request for Thermaphore moist heat pad QTY: 1 is not medically necessary.