

<b>Case Number:</b>	CM14-0158238		
<b>Date Assigned:</b>	10/01/2014	<b>Date of Injury:</b>	05/23/2013
<b>Decision Date:</b>	11/10/2014	<b>UR Denial Date:</b>	09/22/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/26/2014

### 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, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Oklahoma. 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 36 years old male who reported an injury on 05/23/2013. The mechanism of injury reportedly occurred while the injured worker was performing a bending action and a loud pop was observed. He was diagnosed with left leg radiculopathy, L5-S1 spondylolisthesis bilateral L5 PARS effect, L4-L5 disc extrusion, L5-S1 disc bulge, facet arthropathy L5-S1. An MRI was performed on 11/20/2013 and a lumbar epidurogram dated 08/22/2014. Prior treatment included a left L4-L5 and L5-L8 selective nerve root block. The clinical note dated 09/11/2014 noted the injured worker reported continued low back pain rated 4/10 with medication and 5/10 without medication. Upon physical exam, he had flexion to 20 degrees, extension to 10 degrees, left lateral bending to 8 degrees, and right lateral bending to 12 degrees. Motor strength to the left knee with flexion was 4/5, strength with ankle dorsiflexion was 4/5, and strength with hip flexion, hip abduction and knee extension, knee flexion and ankle dorsiflexion on right was normal. The injured worker's medication regimen included Norco 10/325, Fexmid 7.5mg, Motrin 800mg and Protonix Dr. 20mg. The treatment plan included recommendations for L4-5 discectomy of the extruded fragment, LSO brace, pneumatic intermittent compression device and post-operative physical therapy. No rationale for the request was submitted. The request for authorization form was submitted on 09/11/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**COLD THERAPY UNIT 30 DAY RENTAL:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES

**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 pain, Cold/Heat packs.

**Decision rationale:** The request for Cold Therapy unit is not medically necessary. The Official Disability Guidelines state, cold packs are recommended as an option for acute pain. The guidelines recommend at-home local applications of cold packs in the first few days of acute complaint; thereafter, applications of heat packs or cold packs. There is minimal evidence supporting the use of cold therapy, but heat therapy has been found to be helpful for pain reduction and return to normal function. The injured worker reported continued back pain with quantified documentation of pain, rated a 4/10 with medication and 5/10 without medication. The documentation indicates the physician recommended the patient undergo lumbar spine surgery; however, there is a lack of documentation indicating the surgery has been approved and is scheduled in the near future. The requesting physician did not indicate why the injured worker would require continuous flow cryotherapy as opposed to traditional methods of cold therapy application. As such, the request is not medically necessary.

**PNEUMATIC INTERMITTENT COMPRESSION DEVICE:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg, Compression garments.

**Decision rationale:** The request for Pneumatic intermittent compression device is not medically necessary. The Official Disability Guidelines note compression stockings that are effective in the management of preventing edema and deep vein thrombosis. Although mechanical methods do reduce the risk of deep vein thrombosis, there is no evidence that they reduce the main threat, the risk of pulmonary embolism (PE), fatal PE, or total mortality. In contrast, pharmacological methods significantly reduce all of these outcomes. They recommend stockings for prevention of VTE, except in stroke patients. The injured worker reported continued back pain with quantified documentation of pain, rated a 4/10 with medication and 5/10 without medication. The documentation indicates the physician recommended the patient undergo lumbar spine surgery; however, there is a lack of documentation indicating the surgery has been approved and is scheduled in the near future. The physician did not indicate why the injured worker would need a pneumatic intermittent compression device as opposed to compression stockings. Additionally, there is no indication that the injured worker is at risk for developing deep vein thrombosis. As such, the request is not medically necessary.

