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| Case Number: | CM14-0169709 | | |
| Date Assigned: | 10/20/2014 | Date of Injury: | 08/07/2008 |
| Decision Date: | 11/20/2014 | UR Denial Date: | 09/29/2014 |
| Priority: | Standard | Application Received: | 10/14/2014 |

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 Occupational Medicine 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:

According to the records made available for review, this is a 49-year-old female with an 8/7/08 date of injury, and status post L4-5 Fusion Revision and Bilateral Foraminotomy and Microdiscectomy L3-4 11/6/13. At the time (9/29/14) of request for authorization for ARS-pad/wrap purchase and ARS-hot/cold compression purchase, there is documentation of subjective (continued severe dysfunctional left leg radiculopathies) and current diagnoses (left-sided foraminal stenosis from recurrent disc herniation of the L3-4 level, foraminal stenosis at the L4-5 level from bony hyperostosis and residual disc herniation, status post lumbar fusion at L4-5 and bilateral lumbar foraminotomy and microdiscectomy at L3-4 11/6/13), and treatment to date (injections, medications and physical therapy). 7/19/14 medical report identifies a request for bilateral L3-4, L4-5 revision Laminoforaminotomy, Microdiscectomy, and Resection of Bony Hyperostosis.

IMR ISSUES, DECISIONS AND RATIONALES

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

ARS-Pad/Wrap Purchase: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low

Back, Cold/Heat Packs Other Medical Treatment Guideline or Medical Evidence: PMID: 18214217 PubMed - indexed for Medline

Decision rationale: MTUS reference to ACOEM guidelines identifies at-home applications of local heat or cold to the low back as an optional clinical measure for evaluation and management of low back complaints. ODG identifies that there is minimal evidence supporting the use of cold therapy. Medical Treatment Guidelines identifies that exact recommendations on application, for postoperative cold therapy utilization following lumbar spine surgery, on time and temperature cannot be given. Therefore, based on guidelines and a review of the evidence, the request for ARS-pad/wrap purchase is not medically necessary.

ARS-Hot/Cold Compression Purchase: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Procedures

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Cold/heat packs Other Medical Treatment Guideline or Medical Evidence: PMID: 18214217 PubMed - indexed for Medline

Decision rationale: MTUS reference to ACOEM guidelines identifies at-home applications of local heat or cold to the low back as an optional clinical measure for evaluation and management of low back complaints. ODG identifies that there is minimal evidence supporting the use of cold therapy. Medical Treatment Guidelines identifies that exact recommendations on application, for postoperative cold therapy utilization following lumbar spine surgery, on time and temperature cannot be given. Therefore, based on guidelines and a review of the evidence, the request for ARS-Hot/Cold Compression Purchase is not medically necessary.