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| Case Number: | CM14-0027080 | | |
| Date Assigned: | 06/20/2014 | Date of Injury: | 04/23/2012 |
| Decision Date: | 08/13/2014 | UR Denial Date: | 01/30/2014 |
| Priority: | Standard | Application Received: | 03/04/2014 |

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:

The injured worker is a 53-year-old female who reported an injury on 03/01/1997 through 08/23/2012 due to continuous trauma. The injured worker complained of right sided low back pain. She is post-op medial branch ablation at the L3, L4, and L5 of the left side 02/2014. She reported that she is functioning better with less pain on the left but now the pain on the right side tended to be the limiting factor. There was no measurable pain level documented. Physical examination dated 04/29/2014 revealed that the injured worker had tenderness over the right sided facet at the L4-5 and L5-S1 level. She had a positive facet loading test on the right. The injured worker had minimal tenderness on the left side where the ablation took place. There was no range of motion or motor strength reports documented in the submitted report. The only diagnostics submitted in the report was an MRI of the left knee that was done on 10/30/2012. The injured worker has diagnoses of lumbar sprain/strain, facetogenic low back pain post L4-5 and L5-S1 with radiofrequency ablation on the left with residual pain on the right. Past medical treatment includes pain medication consultations, psychological consultations, and radiofrequency ablation of the facet joints in the lumbar on the left side at the level of L4-5, L5-S1 level of median branch, facet blocks in the lumbar area, physical therapy, acupuncture, and medication therapy. Medications include Tizanidine, Tramadol, Motrin, and Zolpidem. No duration, frequency, or dosage were submitted in the report. The treatment plan is for the purchase of a XXXXXXXXXX hot and cold contrast therapy with compression for 60 days. The rationale and the request for authorization form were not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

**PURCHASE OF A [REDACTED] HOT AND COLD CONTRAST THERAPY
W/COMPRESSION FOR 60 DAYS:**

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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/heat packs.

Decision rationale: The request for purchase of a [REDACTED] hot and cold contrast therapy w/compression for 60 days is non-certified. The Official Disability Guidelines state continuous low-level heat wrap therapy is superior to both acetaminophen and ibuprofen for therapy of low back pain. The evidence for the application of cold treatment to low back pain is more limited than heat therapy, with only 3 poor quality studies located that support its use, but studies confirm that it may be a low risk low cost option. There is minimal evidence supporting the use of cold therapy, but the therapy has been found to be helpful for pain reduction and return to normal function. Therefore, given the requested unit includes cold therapy which has minimal evidence to support its use, the purchase of a [REDACTED] hot and cold contrast therapy w/compression unit is not medically necessary. Also, there was a lack of documentation indicating at home applications of hot/cold packs had not been beneficial for the injured worker. As such, the request for purchase of a [REDACTED] hot and cold contrast therapy w/compression for 60 days is non-certified.