

Case Number:	CM14-0027848		
Date Assigned:	06/16/2014	Date of Injury:	06/04/2003
Decision Date:	08/11/2014	UR Denial Date:	02/10/2014
Priority:	Standard	Application Received:	03/05/2014

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 Anesthesia, has a subspecialty in Acupuncture & Pain 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:

A 48 years old male injured worker with date of injury 6/4/03 and related low back pain. Per progress report dated 1/7/14, the injured worker reported pain 7/10 in intensity that radiated into his legs bilaterally, causing numbness and tingling into the toes with occasional burning. He has been approved for left sacroiliac joint rhizotomy. MRI of the lumbar spine dated 7/13/11 revealed disc desiccation at the L3-L4 level with mild hypertrophy of ligamentum flavum bilaterally; there was a disc desiccation at the L4-L5 level with hypertrophy of ligamentum flavum bilaterally; there was a disc desiccation at the L5-S1 level with a broad-based asymmetric posterior disc protrusion, there was no evidence of central or foraminal stenosis. Treatment to date has included injections, rhizotomy, chiropractic manipulation, physical therapy, and medication management. The date of Utilization Review decision was 2/10/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hot/Cold therapy unit: Upheld

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, Continuous-flow cryotherapy.

Decision rationale: The MTUS and ODG guidelines are silent on the use of hot/cold contrast therapy units. The ODG states continuous-flow cryotherapy is Recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage; however, the effect on more frequently treated acute injuries (eg, muscle strains and contusions) has not been fully evaluated. The available scientific literature is insufficient to document that the use of continuous-flow cooling systems (versus ice packs) is associated with a benefit beyond convenience and patient compliance (but these may be worthwhile benefits) in the outpatient setting. Review of the documentation submitted for review indicates that the request is for hot/cold contrast therapy with compression, which is not supported by the guidelines. Therefore, the request for Hot/Cold therapy unit is not medically necessary and appropriate.