

Case Number:	CM14-0033190		
Date Assigned:	03/19/2014	Date of Injury:	08/01/2013
Decision Date:	07/14/2014	UR Denial Date:	03/03/2014
Priority:	Standard	Application Received:	03/14/2014

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a Physician Reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The Physician Reviewer is Board Certified in Internal Medicine and Emergency Medicine, and is licensed to practice in Florida. 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 Physician 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:

This patient is a 44-year-old with a date of injury of 08/01/13. A progress report associated with the request for services, dated 01/31/14, identified subjective complaints of low back pain. Objective findings included tenderness to palpation of the lumbar spine with decreased range-of-motion. Motor and sensory function was normal. Diagnoses included lumbar disc disease. Treatment has included physical and chiropractic therapy as well as oral analgesics. A Utilization Review determination was rendered on 03/03/14 recommending non-certification of "hot and cold therapy unit".

IMR ISSUES, DECISIONS AND RATIONALES

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

HOT AND COLD THERAPY UNIT: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308. Decision based on Non-MTUS Citation Low Back, Heat Therapy; Cold/Heat Packs.

Decision rationale: The Medical Treatment Utilization Schedule (MTUS) indicates that at-home applications of local heat or cold to the low back are optional therapy. The Official Disability

Guidelines (ODG) indicates that heat therapy is recommended as an option. They note that ThermaCare and HeatWrap are the most effective products. They also indicate that cold/heat packs are recommended as an option for acute pain. They indicate that though heat therapy has been found to be effective, there is minimal evidence supporting the use of cold therapy. In this case, the type of hot and cold therapy unit is not specified. Further, there is minimal evidence for the value of cold therapy. Therefore, the record does not document the medical necessity for a Hot & Cold Therapy Unit.