

Case Number:	CM14-0054314		
Date Assigned:	07/07/2014	Date of Injury:	07/11/2013
Decision Date:	08/08/2014	UR Denial Date:	04/01/2014
Priority:	Standard	Application Received:	04/23/2014

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 and Rehabilitation, has a subspecialty in Interventional spine 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:

This patient is a 50-year-old male with date of injury of 07/11/2013. Per treating physician's report on 03/06/2014, the patient presents with low back pain, with some improvement following SI joint injection from 02/06/2014, the patient has radiating symptoms to right lower extremity, with numbness and tingling. Objective findings showed positive straight leg raise, tenderness to palpation in bilateral SI joints. Listed diagnoses are: Lumbar sprain/strain; chronic low back pain with radicular symptoms to right lower extremity, MRI showed 3-mm disk bulge; facet arthropathy at L4-L5; mild bilateral foraminal stenosis at L3-L4 with minimal degenerative disk changes and facet changes. Recommendation was for lumbar epidural steroid injection x3, ThermoKool hot and cold contrast therapy with compression for 60 days, and lumbosacral brace.

IMR ISSUES, DECISIONS AND RATIONALES

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

Thermo Cool Hot and Cold Contrast therapy with compression QTY: 1.00: 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), Shoulder and knee section.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) ODG knee chapter Continuous-flow cryotherapy.

Decision rationale: This patient presents with chronic persistent low back pain with MRI demonstrating multilevel degenerative disk changes. The current request is for ThermoKool hot and cold contrast therapy with compression. The treating physician wants to try this for 60 days, indicating that this is to be used for pain control, reduction of inflammation, and increase circulation. While MTUS Guidelines do not discuss these types of hot/cold treatment units, ODG Guidelines do not support use of hot/cold continuous flow type of modalities other than for postoperative care following surgeries such as shoulder and knee conditions. This patient presents with chronic low back pain and ODG Guidelines specifically states that it is not recommended for chronic pain. Therefore, Thermo Cool Hot and Cold Contrast therapy with compression quantity: 1.00 is not medically necessary.

Lumbosacral brace: 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: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) ODG guidelines, online, low back chapter for lumbar supports.

Decision rationale: This patient presents with chronic low back and lower extremity pain. MRI of the lumbar spine demonstrated 3-mm disk bulge with moderate facet hypertrophies at L4-L5 and foraminal stenosis at L3-L4 with minimal degenerative disk changes. ACOEM Guidelines do not typically support use of lumbar brace. ODG Guidelines states that it may be indicated for spondylolisthesis, compression fractures, instability problems, and possibly nonspecific low back pain, but states that there is a very low quality study to support use of lumbar brace for nonspecific low back pain. This patient does appear to present with nonspecific low back pain and possibly radiculopathy. There is lack of guidelines to support that lumbar braces can provide significant reduction of pain in the long run. Therefore, Lumbosacral brace is not medically necessary.