

<b>Case Number:</b>	CM14-0071057		
<b>Date Assigned:</b>	07/14/2014	<b>Date of Injury:</b>	03/05/2012
<b>Decision Date:</b>	09/22/2014	<b>UR Denial Date:</b>	05/01/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/16/2014

### 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 Family Medicine and is licensed to practice in North Carolina. 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 44 year old with a reported date of injury of 03/05/2012 that occurred as a result of a fall. The patient has the diagnoses of chronic mid/low back pain, thoracolumbar spondylosis and myofascial pain syndrome. Previous treatment modalities had included radiofrequency neurotomy. Per the progress notes provided by the primary treating physician dated 04/21/2014, the patient had complaints of mid/low back pain. The patient was tolerating medications and only using pain medication as needed. There was no physical exam noted. Treatment recommendations included continuation of medications and Thermacare heat pads.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Durable Medical Equipment:** 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): Low Back Chapter, cold/hot packs.

**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 complaints, cold/hot packs.

**Decision rationale:** The California chronic pain medical treatment guidelines and the ACOEM do not specifically address the requested durable medical equipment, which is a Thermacare heat pad. The ODG section on low back complaints and cold/hot packs states: Recommended as an option: At-home local applications of cold packs in the first few days of acute complaint; thereafter, applications of heat packs or cold packs. Continuous low -level heat wrap therapy is superior to both acetaminophen and ibuprofen for treating low back pain. While heat therapy is a recommended option for treatment of low back pain, the specific item requested is no more effective than other at-home local applications such as a heating pad. The provided documentation does not specify why the requested item is specifically needed over other at-home conventional heat therapy sources. Without objective documentation of the reason why this specific heat pad is needed over other options, the request cannot be therefore be medically necessary.