

<b>Case Number:</b>	CM14-0081933		
<b>Date Assigned:</b>	07/21/2014	<b>Date of Injury:</b>	10/03/2007
<b>Decision Date:</b>	09/11/2014	<b>UR Denial Date:</b>	05/22/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/03/2014

### 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 Occupational 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:

This is a 47-year-old female with a 10/3/07 date of injury. The mechanism of injury was not noted. According to a progress report dated 6/3/14, the patient complained of low back pain with significant radicular symptoms to both lower extremities, which she rated from 0-10 as 8 in intensity. Objective findings: tenderness to palpation about the lumbar paravertebral musculature and sciatic notch region; trigger points and taut bands with tenderness to palpation noted throughout; sensation decreased along the posterior lateral thigh, lateral calf, and dorsum of the foot at about the L5 or S1 distribution. Diagnostic impression: lumbar post-laminectomy syndrome with bilateral lower extremity radiculopathy, left greater than right; cervical myoligamentous injury; reactionary depression/anxiety; medication induced gastritis. Treatment to date include: medication management, activity modification, L4-5 laminectomy/discectomy in July of 2009, L4-5 anterior posterior fusion on 8/26/10, and trigger point injections. A UR decision dated 5/22/14 denied the requests for ARS pad/wrap for purchase, cervical traction for 5 month purchase, lumbar traction for purchase, and ARS-hot/cold compression for purchase. Regarding ARS-hot/cold compression for purchase and ARS pad/wrap for purchase, the documentation failed to provide a rationale for the need of hot/cold compression therapy. Additionally, as the request for a hot/cold compression therapy device is not supported, the request for purchase of pad/wrap is not supported. Regarding cervical traction and lumbar traction, the documentation submitted for review failed to provide a rationale for the need of a traction device.

### IMR ISSUES, DECISIONS AND RATIONALES

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

### **ARS Pad/Wrap for Purchase:**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Aetna Clinical Policy Bulletin: Cryoanalgesia and Therapeutic Cold.

**Decision rationale:** CA MTUS and ODG do not address this issue. Aetna considers the use of the Hot/Ice Machine and similar devices (e.g., the Hot/Ice Thermal Blanket, the TEC Thermoelectric Cooling System (an iceless cold compression device), the Vital Wear Cold/Hot Wrap, and the Vital Wrap) experimental and investigational for reducing pain and swelling after surgery or injury. Studies in the published literature have been poorly designed and have failed to show that the Hot/Ice Machine offers any benefit over standard cryotherapy with ice bags/packs; and there are no studies evaluating its use as a heat source. Because the ARS-hot/cold compression was not found to be medically necessary, this associated request for supplies for the unit cannot be substantiated. Therefore, the request for ARS pad/wrap for purchase is not medically necessary.

### **Cervical Traction for 5 Month Purchase: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back Chapter.

**Decision rationale:** ODG recommends home cervical patient controlled traction for patients with radicular symptoms, in conjunction with a home exercise program. However, CA MTUS states that there is no high-grade scientific evidence to support the effectiveness or ineffectiveness of passive physical modalities such as traction. In addition, ODG does not recommend powered traction devices. A specific rationale identifying why cervical traction unit is required in this patient despite lack of guideline support was not provided. Therefore, the request for cervical traction for 5 month purchase is not medically necessary.

### **Lumbar Traction for Purchase: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-300. Decision based on Non-MTUS Citation Official Disability Guidelines, Treatment Index, 11th edition (web), 2013, low back.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter.

**Decision rationale:** CA MTUS states that traction has not been proved effective for lasting relief in treating low back pain. Because evidence is insufficient to support using vertebral axial decompression for treating low back injuries, it is not recommended. A specific rationale identifying why a lumbar traction unit is required in this patient despite lack of guideline support was not provided. Therefore, the request for lumbar traction for purchase is not medically necessary.

**ARS- Hot/Cold Compression for Purchase:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-300. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Aetna Clinical Policy Bulletin: Cryoanalgesia and Therapeutic Cold.

**Decision rationale:** CA MTUS and ODG do not address this issue. [REDACTED] considers the use of the Hot/Ice Machine and similar devices (e.g., the Hot/Ice Thermal Blanket, the TEC Thermoelectric Cooling System (an iceless cold compression device), the Vital Wear Cold/Hot Wrap, and the Vital Wrap) experimental and investigational for reducing pain and swelling after surgery or injury. Studies in the published literature have been poorly designed and have failed to show that the Hot/Ice Machine offers any benefit over standard cryotherapy with ice bags/packs; and there are no studies evaluating its use as a heat source. There is no documentation that the patient has had a trial of using ice/heat packs. A specific rationale identifying why a hot/cold compression unit is required in this patient despite lack of guideline support was not provided. Therefore, the request for ARS- hot/cold compression for purchase is not medically necessary.