

Case Number:	CM13-0066141		
Date Assigned:	01/03/2014	Date of Injury:	12/06/2007
Decision Date:	01/23/2015	UR Denial Date:	12/04/2013
Priority:	Standard	Application Received:	12/16/2013

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 Rehab, has a subspecialty in Pain Medicine and is licensed to practice in Texas & Ohio. 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 55-year-old male who reported an injury on 12/06/2007. The mechanism of injury was not submitted for clinical review. The diagnoses included lumbosacral sprain/strain with radiculopathy, left lower extremity, with progressive neural deterioration, exceedingly large disc herniation with cephalad extrusion at the L5-S1 level, compressing the left side of the canal, moderate spinal stenosis L4-5, history of sleep disorder, sexual dysfunction, depressed mood treating with other specialists in the respective fields. Previous treatments included medication. On 10/21/2013, it was reported the injured worker complained of left lower extremity radicular pain, weakness, and pain in his lower back. The injured worker reported the low back pain is more problematic at his leg. On the physical examination, the provider indicated the patient ambulates with the utilization of a cane. There was a positive straight leg raise on the left side, as well as persistent weakness on the left. The provider requested postop DME TEC system, iceless cold therapy unit with DVT and lumbar wrap. The request for authorization was submitted and dated on 11/21/2013.

IMR ISSUES, DECISIONS AND RATIONALES

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

Post op DME; TEC System (iceless cold therapy unit with DVT and lumbar wrap): 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); cryotherapy devices

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Cold/heat packs

Decision rationale: The California MTUS/ACOEM Guidelines state at home local applications of heat or cold are as effective as those performed by therapists. In addition, the Official Disability Guidelines recommend cold/heat as an option for acute pain, at home local applications of cold packs in the first few days of acute complaint, thereafter applications of heat or cold packs. Continuous low level of heat wrap therapy is superior to both acetaminophen and/or ibuprofen for treating low back pain. There is evidence of application of cold treatment to low back be more limiting than heat therapy. There was lack of significant documentation indicating the injured worker's surgical intervention had been found to be medically necessary. Additionally, the request submitted failed to include the length of time the patient is to utilize the coldless therapy unit. Additionally, the request submitted failed to indicate if the request was for rental or purchase. As such, the request is not medically necessary.