

<b>Case Number:</b>	CM14-0103712		
<b>Date Assigned:</b>	07/30/2014	<b>Date of Injury:</b>	08/17/2013
<b>Decision Date:</b>	12/11/2015	<b>UR Denial Date:</b>	06/20/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/07/2014

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 34-year-old male, with a reported date of injury of 08-17-2013. The diagnoses include lumbar spine sprain and strain, rule out herniated nucleus pulposus; lumbar radiculopathy; sleep disorder; mood disorder; and anxiety disorder. The progress report dated 12-03-2013 indicates that the injured worker complained of burning, radicular low back pain, with radiation into the left leg. He rated the pain 5-8 out of 10 (11-10-2013 and 12-03-2013). The pain was associated with numbness and tingling of the left lower extremity. The pain was aggravated by prolonged positioning including sitting, standing, walking, bending, arising from a sitting position, ascending or descending stairs, and stooping. It was noted that the pain was also aggravated by activities of daily living. The injured worker stated that the symptoms persisted, but the medications offer him temporary relief of pain and improved his ability to have restful sleep. The injured worker has been instructed to return to modified work. The objective findings (11-10-2013) include no acute distress; ability to heel and toe walk; pain with heel walking; tenderness to palpation at the paralumbar muscles, quadratus lumborum, lumbosacral junction, and at the PSIS; trigger point on the left; sciatic notch tenderness, greater on the left; decreased lumbar spine range of motion; positive bilateral Lasegue's differential; and slightly decreased sensation to pinprick and light touch at the L4, L5, and S1 in the left lower extremity. On 11-20-2013, it was documented that the injured worker was temporarily partially disabled from 11-05-2013 to 12-06-2013. The diagnostic studies to date have included urine drug screens on 11-05-2013 with consistent findings; and an MRI of the lumbar spine on 10-21-2013 which showed early disc desiccation at L4-5 and L5-S1, diffuse disc protrusion with compression of the

thecal sac at L4-5, and focal central disc extrusion with annular tear indenting the thecal sac at L5-S1. Treatments and evaluation to date have included Ibuprofen and Hydrocodone. The treating physician requested rental of hot and cold water circulating therapy unit for four months (date of service: 12-06-2013). On 06-20-2014, Utilization Review (UR) non-certified the request for rental of hot and cold water circulating therapy unit for four months (date of service: 12-06-2013).

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Retrospective DOS: 12/6/2013: Four months rental of hot and cold water circulating therapy unit: Upheld**

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

**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, Cold/Heat Therapy, page 343.

**Decision rationale:** Regarding Hot/Cold therapy, guidelines state it is recommended as an option after surgery, but not for nonsurgical treatment with 4 months rental. The request for authorization does not provide supporting documentation for purchase beyond the guidelines criteria. There is no documentation that establishes medical necessity or that what is requested is medically reasonable outside recommendations of the guidelines which note local application of heat or cold is as effective as those performed by therapists and high tech devices have not demonstrated superior efficacy over the use of traditional non-motorized heating/ cooling pad modalities. MTUS Guidelines is silent on specific use of hot/cold compression therapy, but does recommend standard hot/cold pack with exercise. The Retrospective DOS: 12/6/2013: Four months rental of hot and cold water circulating therapy unit is not medically necessary and appropriate.