

<b>Case Number:</b>	CM14-0028182		
<b>Date Assigned:</b>	06/13/2014	<b>Date of Injury:</b>	07/03/2010
<b>Decision Date:</b>	01/05/2015	<b>UR Denial Date:</b>	02/10/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/05/2014

### 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 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 49-year-old female patient who reported an industrial injury to her back on 7/1/2010, over four (4) years ago, attributed to the performance of her usual and customary job tasks. The patient is being treated for lumbosacral disc degeneration and lumbosacral neuritis. The patient was being treated with Cymbalta, Norco, ibuprofen, Prilosec, and Tizanidine. The objective findings on examination-included tenderness to palpation over the right posterior sacroiliac spine with intact sensation and symmetrical reflexes; positive Gaenslen's test. The patient was diagnosed with a sacroiliac arthropathy and the treatment plan included a sacroiliac block. The treatment plan included medications to be continued. A ThermoCool hot and cold contrast therapy system with compression was ordered as a rental for 60 days to reduce pain in reduction of pain with increased circulation.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**ThermoCool hot and cold contrast therapy with compression for lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 48.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment, Chapter 13 Knee Complaints Page(s): 48, 300 and 338. Decision based on Non-

MTUS Citation Official Disability Guidelines (ODG); Knee chapter, continuous flow cryotherapy; Low Back Chapter cold/head packs.

**Decision rationale:** The use of the ThermoCool cold/hot circulation units with a compression wrap for the low back are recommended by evidence-based guidelines for hospital use but not for home use. There is no demonstrated medical necessity for this ThermoCool cold/hot therapy unit with appliance to be provided to the patient subsequent to the lower back sprain/strain/DDD for home treatment as opposed to the conventional treatment with cold/hot packs. The medical necessity of the DME for the home treatment of the patient was not supported with objective evidence to support medical necessity. There is no objective evidence to support the home use of the requested cold/hot therapy system as opposed to the customary RICE for the treatment of pain and inflammation. There was no clinical documentation provided to support the medical necessity of the requested DME in excess of the recommendations of the California MTUS. The use of a cold/hot circulation pump is not demonstrated to be medically necessary for the treatment of chronic lower back pain attributed to lumbar spine DDD. There is no demonstrated medical necessity for the 60-day rental of a ThermoCool cold/hot circulation unit for the treatment of the lumbar spine for the cited diagnoses. The cold/hot therapy units are not medically necessary for the treatment of the lumbar spine sprain/strains or lumbar spine DDD as alternatives for the delivery of heat and cold to the back is readily available. The request for authorization of the cold/hot therapy by name brand is not supported with objective medically based evidence to support medical necessity. There is no provided objective evidence to support the medical necessity of the requested cold/hot unit as opposed to the more conventional methods for the delivery of cold/hot for the cited diagnoses. The CA MTUS; the ACOEM Guidelines, and the ODG recommend hot or cold packs for the application of therapeutic cold/hot or heat. The use of hot or cold/hot is not generally considered body part specific. The Official Disability Guidelines chapter on the knee and lower back states a good example of general use for hot or cold. The issue related to the request for authorization is whether an elaborate mechanical compression device is necessary as opposed to the recommended hot or cold pack. There is no demonstrated medical necessity for the requested cold/hot unit for the treatment of the postoperative lumbar spine. There is no demonstrated medical necessity for the requested hot/cold unit for the treatment of the reported chronic low back pain for the diagnosis of lumbar radiculopathy and mild spasms. There is no demonstrated medical necessity for the prescribed ThermoCool hot and cold contrast unit with compression for the lumbar spine; therefore, this request is not medically necessary.