

<b>Case Number:</b>	CM15-0143500		
<b>Date Assigned:</b>	08/05/2015	<b>Date of Injury:</b>	03/15/2009
<b>Decision Date:</b>	09/02/2015	<b>UR Denial Date:</b>	06/17/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/23/2015

### 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: Preventive Medicine, Occupational Medicine

### 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 59 year old female who sustained an industrial injury on March 15, 2009 incurring low back injuries. She was diagnosed with lumbar disc herniation, lumbar foraminal stenosis and lumbar disc protrusions. Treatment included pain medications, muscle relaxants, sleep aides, anti-inflammatory drugs, topical analgesic gel, radiofrequency ablation, and activity restrictions. The provider's progress note dated June 10, 2015 reported the injured worker complained of persistent low back pain radiating to the left buttock and left anterior thigh. The pain and spasms have increased and the patient gets buttock pain when sitting. Prior use of ice packs were not effective because the cold dissipated too quickly. Exam noted limited lumbar range of motion and spasms in the lumbar paravertebral muscles. Reflex and motor exams of the lower extremities were normal. The treatment plan that was requested for authorization included a gel pillow and an active ice therapy system.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Gel pillow:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back, Pillow.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Brienza D, Kelsey S, Karg P, et al. A Randomized Clinical Trial on Preventing Pressure Ulcers with Wheelchair Seat Cushions. Journal of the American Geriatrics Society. 2010; 58(12): 2308-2314.

**Decision rationale:** An orthopedic pillow is a pillow designed to correct body positioning in bed or while lying/sitting on any other surface. The pillows are made from a number of substances to include foams, gels or water. They are designed to conform with orthopedic guidelines to ensure the right placement and support of one or more specific parts of the body and to provide safe and healthy rest. When used as a seat cushion it will decrease the formation of pressure sores or ulcers. Evidence-based studies recommended their use in patients who are wheelchair bound or at risk of developing pressure ulcers. There are no evidence-based studies or guidelines that addresses effectiveness of this therapeutic modality in treating low back pain or buttock pain of an orthopedic origin. The MTUS does not comment in its use. At this point in the care of this patient medical necessity for use of this modality has been established. The request is medically necessary.

**Active ice therapy system:** 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), Neck and Upper Back, Continuous Flow Cryotherapy.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chapter 3 Initial Approaches to Treatment Page(s): 44, 48-9; 300, Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-9.

**Decision rationale:** Ice packs and active cold therapy machines are devices, which delivered cold to a specific body part. They are used as a passive therapy for cooling of parts of the body in order to manage pain. Localized application of cold causes the blood vessels in that area to contract, decreasing perfusion to the targeted tissue and limiting swelling and inflammation. In general, physical methods for treating injuries can be active or passive. Passive therapies may be effective in the first few weeks after an injury but have not been shown to be effective after the period of the initial injury. Active therapy directed towards specific goals, such as physical therapy done at a physical therapy clinic or in the home, is more likely to result in a return to functional activities. This patient is well past her initial injury and has not had recent surgery. Addition of a ice packs to her therapy has no evidence-based support for its use. Medical necessity for use of ice packs has not been established. The request is not medically necessary.