

Case Number:	CM15-0147399		
Date Assigned:	08/10/2015	Date of Injury:	08/26/2014
Decision Date:	09/11/2015	UR Denial Date:	06/24/2015
Priority:	Standard	Application Received:	07/29/2015

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: 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 female, who sustained an industrial injury on 8-26-2014. She reported back pain from repetitive bending, lifting and stooping activity. Diagnoses include thoracolumbar sprain-strain, lumbar sprain-strain. Treatments to date include medication therapy, physical therapy, chiropractic therapy, and acupuncture treatments. Currently, she complained of ongoing pain in the neck, upper and lower back. On 6-12-15, the physical examination documented tenderness to the cervical, thoracic and lumbar areas with lumbar muscle spasm noted. The straight leg raising test and Kemp's test were positive. There was decreased range of motion noted. The plan of care included a request to authorize durable medical equipment (DME) cold unit therapy (home use).

IMR ISSUES, DECISIONS AND RATIONALES

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

DME: cold unit therapy (home use): 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), Low Back, Cold/heat packs.

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- Lumbar & Thoracic Chapter, under Cold/Heat Packs.

Decision rationale: The patient was injured on 08/26/14 and presents with bilateral lower extremity pain and pain which radiates from the posterior aspects of the bilateral ankles. The request is for a COLD UNIT THERAPY (HOME USE). There is no RFA provided and the patient is not currently working. ODG Guidelines, Low Back- Lumbar & Thoracic Chapter, under Cold/Heat Packs section states, "Recommended as an option for acute pain. At-home local applications of cold packs in first few days of acute complaint; thereafter, applications of heat packs or cold packs. (Bigos, 1999) (Airaksinen, 2003) (Bleakley, 2004) (Hubbard, 2004) Continuous low-level heat wrap therapy is superior to both acetaminophen and ibuprofen for treating low back pain. (Nadler 2003) The evidence for the application of cold treatment to low-back pain is more limited than heat therapy, with only three poor quality studies located that support its use, but studies confirm that it may be a low risk low cost option. (French-Cochrane, 2006) There is minimal evidence supporting the use of cold therapy, but heat therapy has been found to be helpful for pain reduction and return to normal function. (Kinkade, 2007)" There is pain with palpation of bilateral calcaneal bodies, pain with palpation of bilateral plantar fascia, activation of Windlass mechanism, pain with palpation of bilateral calves/Achilles tendon at insertion and with ankle joint dorsiflexion/plantarflexion, tenderness to the cervical/thoracic/lumbar areas with lumbar muscle spasm, a positive straight leg raise, a positive Kemp's test, and a decreased range of motion. The patient is diagnosed with thoracolumbar sprain-strain, lumbar sprain-strain. Treatments to date includes medication therapy, physical therapy, chiropractic therapy, and acupuncture treatments. The reason for the request is not provided. ODG guidelines state that "there is minimal evidence supporting the use of cold therapy, but heat therapy has been found to be helpful for pain reduction and return to normal function." Due to lack of support from guidelines, the request IS NOT medically necessary.