MAXIMUS Federal Services

Case Number:	CM15-0190154		
Date Assigned:	10/22/2015	Date of Injury:	01/05/2010
Decision Date:	12/03/2015	UR Denial Date:	09/16/2015
Priority:	Standard	Application Received:	09/28/2015

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: Illinois, California, Texas
Certification(s)/Specialty: Orthopedic Surgery

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 injured worker is a 61-year-old male who sustained an industrial injury on 1/5/10. Injury occurred while he was moving truck tires. He underwent L5/S1 lumbar decompressive laminectomy, posterior lumbar interbody fusion, and posterolateral fusion in 2010. The 12/17/14 lumbar spine MRI impression documented status post decompressive laminectomy with posterolateral fusion at L5/S1 without complication. There was no current central canal stenosis. There was mild central and moderate foraminal stenosis at L4/5. The 6/12/15 lumbar spine x-rays showed an old stable fusion at L5/S1 with some segmental breakdown at L4/5 where there was moderate stenosis. The 9/2/15 treating physician report cited low back pain radiating to the bilateral lower extremities. Physical exam documented significant tenderness on the right sacroiliac joint, positive bilateral straight leg raise, normal lower extremity muscle strength, normal lower extremity sensation, and diminished Achilles reflexes. The injured worker had a degenerative spondylolisthesis of L4 on L5 with stenosis at the same segment. Authorization was requested for L4/5 anterior lumbar interbody fusion with instrumentation, removal of posterior L5/S1 instrumentation, and posterior L4/5 laminectomy and fusion with instrumentation and associated surgical requests, including the purchase of a hot/cold therapy unit and wrap. The 9/16/15 utilization review certified the requests for lumbar spine surgery, but non-certified the purchase of the hot/cold therapy unit and wrap as this was not supported by guidelines over standard hot/cold packs. The 9/16/15 peer-to-peer discussion notes submitted by the treating physician indicated that a hot/cold therapy unit was nice to have to reduce pain and swelling but

was by no means mandatory. He stated that cold and compression therapy had long been accepted in the medical field as an effective tool for reducing inflammation, pain and swelling. This equipment had been prescribed as an effective pain management modality for the post-operative rehabilitation of this injured worker.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hot Cold Therapy Unit Wrap (purchase): Upheld

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

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Physical Methods. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), Occupational Medical Practice Guidelines, Chapter 12 Low Back Disorders (Revised 2007), Hot and cold therapies, page(s) 160-161.

Decision rationale: The California MTUS are silent regarding hot/cold therapy devices, but recommend at home applications of hot or cold packs. The ACOEM Revised Low Back Disorder Guidelines state that the routine use of high-tech devices for hot or cold therapy is not recommended in the treatment of lower back pain. Guidelines support the use of hot or cold packs for patients with low back complaints. Guideline criteria have not been met. There is no compelling reason submitted to support the medical necessity of a hot/cold therapy unit in the absence of guideline support and over standard hot/cold packs. Therefore, this request is not medically necessary.