

Case Number:	CM15-0210464		
Date Assigned:	10/29/2015	Date of Injury:	02/16/2015
Decision Date:	12/15/2015	UR Denial Date:	10/26/2015
Priority:	Standard	Application Received:	10/26/2015

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: New York, Tennessee
 Certification(s)/Specialty: Emergency 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 52 year old individual with an industrial injury dated 02-16-2015. A review of the medical records indicates that the injured worker is undergoing treatment for headache, right wrist sprain and strain, left hip sprain and strain, loss of sleep and other insomnia. According to the progress note dated 10-08-2015, the injured worker reported head pain rated a 5-6 out of 10 without medications and a 0 out of 10 with medications; right wrist and thumb pain rated a 7 out of 10 without medications and a 3 out of 10 with medications; left hip pain without medications and a 3 out of 10 with medications; and sleep complaints. Objective findings (08-13-2015, 09-10-2015, 10-08-2015) revealed tenderness to palpitation of the right wrist and left hip. Treatment has included MRI of right wrist August of 2015, MRI of lumbar spine on 09-03-2015, prescribed medications, and periodic follow up visits. The utilization review dated 10-26-2015, non-certified the request for Hot and cold unit for home use (1# of 2 consults).

IMR ISSUES, DECISIONS AND RATIONALES

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

Hot/cold unit for home use (1# of 2 consults): Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Aetna Clinical Policy Bulletin: Cryoanalgesia and therapeutic cold.

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 and Thoracic, Cold/heat packs.

Decision rationale: MTUS does not address this topic. Cold/heat packs are recommended as an option for acute pain. At-home local applications of cold packs are recommended in first few days of acute complaint; thereafter, applications of heat packs or cold packs are recommended. Continuous low-level heat wrap therapy is superior to both acetaminophen and ibuprofen for treating low back pain. 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. 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. While heat and cold packs are useful for low back pain, there is no recommendation that a Hot and Cold unit is necessary to supply the heat and cold applications to the affected area. Sufficient heat and cold can be applied with the use of hot packs, cold packs, or heating pad. There is no medical necessity for Hot and cold unit. The request is not medically necessary.