MAXIMUS Federal Services

Case Number:	CM14-0143624		
Date Assigned:	09/12/2014	Date of Injury:	06/19/2014
Decision Date:	10/10/2014	UR Denial Date:	08/25/2014
Priority:	Standard	Application Received:	09/04/2014

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 Physical Medicine and Rehabilitation, has a subspecialty in Interventional Spine, 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 patient presents with low back pain radiating to the right lower extremity with limited range of motion. The treater is requesting a hot/cold compression unit with supplies including pad and wrap for purchase. The MTUS and ACOEM guidelines do not discuss cold therapy units. Therefore, ODG Guidelines are referenced. ODG Guidelines has the following regarding continuous-flow cryotherapy: "Recommended as an option after surgery but not for nonsurgical treatment. Postoperative use generally may be up to 7 days including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic use. However, the effectiveness on more frequently treated acute injuries has not been fully evaluated." This patient is not status post surgery and ODG does not recommend continuous-flow cryotherapy for nonsurgical treatment. Recommendation is for denial.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hot/Cold Compression unit with pad/wrap purchase: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Cold/Heat Packs

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ODG guidelines has the following regarding hot/cold treatments: (L-spine chapter).

Decision rationale: This patient presents with low back pain radiating to the right lower extremity with limited range of motion. The treater is requesting a hot/cold compression unit with supplies including pad and wrap for purchase. The MTUS and ACOEM guidelines do not discuss cold therapy units. Therefore, ODG Guidelines are referenced. ODG Guidelines has the following regarding continuous-flow cryotherapy: "Recommended as an option after surgery but not for nonsurgical treatment. Postoperative use generally may be up to 7 days including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic use. However, the effectiveness on more frequently treated acute injuries has not been fully evaluated." This patient is not status post surgery and ODG does not recommend continuous-flow cryotherapy for nonsurgical treatment. Recommendation is for denial.

LSO Back Support Purchase: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Back Chapter, Lumbar Supports & Back Brace, Post operative

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines guidelines for lumbar.

Decision rationale: This patient presents with low back pain radiating to the right lower extremity with limited range of motion. The treater is requesting an LSO back support brace for purchase. ACOEM Guidelines page 301 on lumbar bracing states, "lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief." ODG Guidelines regarding lumbar support states, "not recommended for prevention; however, recommended as an option for compression fracture and specific treatment of spondylolisthesis, documented instability, and for treatment of nonspecific low back pain, "very low quality evidence, but may be a conservative option." In this case, the patient does not present with fracture, documented instability, or spondylolisthesis to warrant lumbar bracing. Recommendation is for denial.