

Case Number:	CM13-0059387		
Date Assigned:	06/09/2014	Date of Injury:	04/29/2005
Decision Date:	02/18/2015	UR Denial Date:	10/23/2013
Priority:	Standard	Application Received:	11/26/2013

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: Anesthesiology, Pain Management

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

According to the records made available for review, this is a 26-year-old male with a 4/29/05 date of injury, and status post lumbar surgery in 2009. At the time (10/24/13) of the Decision for Retrospective Hot/Cold Water Circulating Heat Pad; DOS 4/29/2013 to 08/18/2013 and Retrospective Sacroiliac Orthosis, Flexible Pelvic-Sacral Prefabricated; DOS 4/29/13-08/18/2013, there is documentation of subjective (constant moderate to severe lumbar spine pain) and objective (tenderness to palpation of paravertebral muscles bilaterally of the lumbar region, mild spasm, and decreased lumbar range of motion secondary to pain) findings, current diagnoses (thoracic or lumbosacral neuritis or radiculitis, unspecified), and treatment to date (medications (including ongoing treatment with Naprosyn, Prilosec, Skelaxin, Tylenol, and Ultracet), activity modifications, and physical therapy). Regarding Retrospective Sacroiliac Orthosis, Flexible Pelvic-Sacral Prefabricated; DOS 4/29/13-08/18/2013, there is no documentation of compression fractures, spondylolisthesis, or documented instability.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective hot/cold water circulating heat pad; dos 4/29/2013 to 08/18/2013: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 299.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Cold/heat packs Other Medical Treatment Guideline or Medical Evidence: PMID: 18214217 PubMed - indexed for MEDLINE.

Decision rationale: MTUS reference to ACOEM guidelines identifies at-home applications of local heat or cold to the low back as an optional clinical measure for evaluation and management of low back complaints. ODG identifies that there is minimal evidence supporting the use of cold therapy. Medical Treatment Guideline identifies that exact recommendations on application, for postoperative cold therapy utilization following lumbar spine surgery, on time and temperature cannot be given. Therefore, based on guidelines and a review of the evidence, the request for retrospective hot/cold water circulating heat pad; dos 4/29/2013 to 08/18/2013 is not medically necessary.

Retrospective sacroiliac orthosis, flexible pelvic-sacral prefabricated; dos 4/29/13 to 08/18/2013: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Lumbar Support.

Decision rationale: MTUS reference to ACOEM identifies that lumbar support have not been shown to have any lasting benefit beyond acute phase of symptom relief. ODG identifies documentation of compression fractures, spondylolisthesis, or documented instability, as criteria necessary to support the medical necessity of lumbar support. Within the medical information available for review, there is documentation of a diagnosis of thoracic or lumbosacral neuritis or radiculitis, unspecified. However, there is no documentation of compression fractures, spondylolisthesis, or documented instability. Therefore, based on guidelines and a review of the evidence, the request for retrospective sacroiliac orthosis, flexible pelvic-sacral prefabricated; dos 4/29/13 to 08/18/2013 is not medically necessary.