

Case Number:	CM15-0117199		
Date Assigned:	06/25/2015	Date of Injury:	07/07/1985
Decision Date:	07/27/2015	UR Denial Date:	06/16/2015
Priority:	Standard	Application Received:	06/17/2015

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: 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 60 year old female, who sustained an industrial/work injury on 7/7/85. She reported initial complaints of back pain. The injured worker was diagnosed as having chronic pain, lumbosacral degenerative disc disease, radicular pain, and opioid dependence. Treatment to date has included medication. Currently, the injured worker complains of chronic low back pain that radiated into bilateral lower extremities. Sleep was affected due to pain. Per the primary physician's progress report (PR-2) on 6/11/15, examination notes anxiety, difficulty getting up from chair, normal gait, stiffness with posture, 5/5 muscle strength, decreased range of motion in the lumbosacral paraspinals. Current plan of care included medication, further pain management regarding radiofrequency ablation and spinal cord stimulator, and medication adjustment. The requested treatments include Thermacare MIS for Back & Hip.

IMR ISSUES, DECISIONS AND RATIONALES

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

Thermacare MIS for Back & Hip, Qty 90: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back - Lumbar & Thoracic (Acute & Chronic): Heat therapy.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG: Low back: Heat therapy.

Decision rationale: MTUS Chronic pain and ACOEM Guidelines do not have any sections that relate to this topic. As per Official Disability Guidelines heat therapy is recommended as an option. A number of studies show continuous low-level heat wrap therapy to be effective for treating low back pain. While it may be recommended, documentation does not support any objective evidence of improvement despite chronic use. Patient continue to be on high dose pain medication and function is limited by pain. Request for thermacare is not medically necessary by documentation.