

Case Number:	CM15-0125664		
Date Assigned:	07/10/2015	Date of Injury:	02/28/2014
Decision Date:	08/07/2015	UR Denial Date:	06/18/2015
Priority:	Standard	Application Received:	06/29/2015

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 34-year-old female who sustained an industrial injury on 2/28/14. Injury occurred when she came to the aid of a co-worker who had slipped and was about to fall. Past medical history was positive for diabetes, morbid obesity, and hypertension. Conservative treatment included medications, physical therapy, epidural injections, trigger point injections, and activity modification. The 5/19/15 lumbar spine MRI impression documented decreased in the since of the previous disc protrusion at L4/5 and associated mild spinal stenosis. At L3/4, there was a 7 mm central, right paramedian disc protrusion resulting in moderate spinal stenosis with impingement upon the right L4 nerve roots. At L5/S1, there was a 2 mm central disc protrusion with no nerve root impingement. The 5/20/15 treating physician report cited low back pain radiating into the buttocks and legs with weakness and loss of some bladder control. She had presented to the emergency room the day prior due to unbearable pain and difficulty walking. Physical exam documented significant paralumbar tenderness, with severely limited active thoracolumbar range of motion. Straight leg raise was markedly positive on the right and mildly positive on the left. There was ankle dorsiflexion and plantar flexion weakness with decreased dorsal foot sensation. Imaging showed chronic disc degeneration at L3/4, L4/5, and L4/5, and prominent central posterior disc herniation at L3/4 and L4/5 with thecal sac compression and spinal stenosis. Authorization was requested for L3/4 and L4/5 anterior lumbar interbody fusion with instrumentation, and posterior bilateral L3/4 and L4/5 lumbar laminectomy/laminotomy with assistant vascular co-surgeon, assistant surgeon, inpatient hospitalization for 3 to 4 days, lumbar brace purchase, pre-operative vascular surgery consult,

pre-operative medical clearance, and purchase of a hot/cold therapy unit with wrap. The 6/17/15 utilization review certified the requests for L3/4 and L5/S1 ALIF with instrumentation and posterior bilateral L3/4 and L4/5 laminectomy/laminotomy with associated assistant vascular co-surgeon, assistant surgeon, inpatient hospitalization for 3 to 4 days, lumbar brace purchase, pre-operative vascular surgeon consult, and pre-operative medical clearance. The request for purchase of a hot/cold therapy unit with wrap was non-certified based on evidence based medical guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Associated surgical service: Hot/Cold therapy unit with wrap - purchase for the low back:
Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Lumbar & Thoracic Chapter, Cold/Heat packs and on the Non-MTUS BlueCross BlueShield, Durable Medical Equipment Section - Cooling Devices Used in the Home Setting. DME Policy No: 7, Revise/Effective Date: 01/07/2005.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 299. 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. Therefore, this request is not medically necessary.