

<b>Case Number:</b>	CM15-0129137		
<b>Date Assigned:</b>	07/20/2015	<b>Date of Injury:</b>	09/02/2013
<b>Decision Date:</b>	08/14/2015	<b>UR Denial Date:</b>	06/24/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/02/2015

### 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 41-year-old male who sustained an industrial injury on 9/2/13. Injury occurred relative to physical training activities while employed as a custody assistant. Past medical history was positive for hypertension. Social history was negative for smoking. Conservative treatment included chiropractic treatment, physical therapy, injections, and medications. The 4/28/15 lumbar spine MRI impression documented a midline and left paracentral disc protrusion at L4/5 with abutment of the descending L5 nerve roots bilaterally with moderate central canal narrowing. There was a biforaminal disc protrusion abutting the exiting L4 nerve roots bilaterally. The 5/27/15 initial spine surgery report cited constant low back pain radiating into the heels with numbness and tingling and muscle cramping. Functional difficulty was noted in activities of daily living. Associated symptoms included sexual dysfunction, anxiety, and depression. Lumbar spine exam documented tenderness at the L4/5 and L5/S1 levels, along the superior iliac crest and bilateral sciatic notch. Physical exam documented limited lumbar range of motion, normal gait, normal heel/toe walk, 4+/5 left extensor hallucis longus weakness, +2 and symmetrical lower extremity deep tendon reflexes, and normal sensation. X-rays documented no instability on flexion/extension views. The diagnosis included broad-based disc protrusion and lateral recess stenosis at L4/5. Authorization was requested for bilateral L4/5 laminectomy with discectomy on the left side and associated surgical requests including a TEC System (Iceless Cold Therapy Unit with DVT and Lumbar Wrap) purchase. The 6/24/15 utilization review certified the request for bilateral L4/5 laminectomy and discectomy, with assistant surgeon, pre-op clearance, and 1 to 2 days inpatient stay. The request for a TEC System (Iceless Cold Therapy Unit with DVT and Lumbar Wrap) purchase was non-certified as there was no guideline support for the use of cold therapy over standard cold packs.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Associated Surgical Service: TEC System (Iceless Cold Therapy Unit with DVT and Lumbar Wrap) Purchase:** 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.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 299. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg; Venous Thrombosis and Other Medical Treatment Guidelines 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 cold therapy devices and deep vein thrombosis prophylaxis, but recommend at home applications of cold packs. The ACOEM Revised Low Back Disorder Guidelines state that the routine use of high-tech devices for cold therapy is not recommended in the treatment of lower back pain. Guidelines support the use of cold packs for patients with low back complaints. The Official Disability Guidelines recommend identifying subjects who are at a high risk of developing venous thrombosis and providing prophylactic measures, such as consideration for anticoagulation therapy. Guideline criteria have not been met. There is no compelling reason submitted to support the medical necessity of a cold therapy unit in the absence of guideline support. There are limited DVT risk factors identified for this patient. There is no documentation that anticoagulation therapy would be contraindicated, or standard compression stockings insufficient, to warrant the use of mechanical prophylaxis. Therefore, this request is not medically necessary.