

<b>Case Number:</b>	CM15-0063420		
<b>Date Assigned:</b>	04/09/2015	<b>Date of Injury:</b>	12/13/2013
<b>Decision Date:</b>	05/19/2015	<b>UR Denial Date:</b>	03/23/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/03/2015

### 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 male with a date of injury of 12/13/13. Injury occurred relative to cumulative trauma from unloading tires and rims. Past medical history was reported as unremarkable. He had no known allergies. The 10/28/14 lumbar spine MRI impression documented L4/5 and L5/S1 lumbar spondylosis. At L5/S1, there was a posterocentral and left paracentral disc protrusion displacing the thecal sac and left S1 nerve root posteriorly, with moderate to severe left L5/S1 neuroforaminal narrowing. At L4/5, there was a posterior disc protrusion with marked bilateral neuroforaminal narrowing. The 11/24/14 treating physician report cited continued left leg pain with numbness and tingling to the left foot and pain. He had pain with activities of daily living. Physical exam revealed decreased left S1 sensation, absent left Achilles reflex, and positive straight leg raise on the left. MRI showed a large left sided L5/S1 disc herniation with impingement of the left S1 nerve root. The treatment plan recommended left sided L5/S1 hemilaminectomy and microdiscectomy. Associated surgical requests included motorized cold therapy unit, DVT (deep vein thrombosis) unit, front wheel walker, 3 in 1 commode, and LSO back brace. The 3/23/15 utilization review certified a request for left sided L5/S1 hemilaminectomy and microdiscectomy and associated surgical requests for 3-in-1 commode, front wheel walker, and LSO back brace. The request for a post-op cold therapy unit purchase was non-certified as there was no demonstrated significant clinical benefit over topical ice packs. The request for a DVT unit was non-certified as there was no indication that the injured worker was at a higher than normal risk for developing DVT, or that this unit was superior to oral prophylaxis and/or compression garments.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Post op cold therapy unit 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.

**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 MTUS, 2009.

**Decision rationale:** The California MTUS are silent regarding cold therapy devices, 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 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 cold therapy unit in the absence of guideline support and over standard cold packs. Therefore, this request is not medically necessary.

**DVT Unit:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg, Venous Thrombosis.

**Decision rationale:** The California MTUS are silent with regard to deep vein thrombosis (DVT) prophylaxis. The Official Disability Guidelines (ODG) generally 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 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.