MAXIMUS Federal Services

Case Number:	CM15-0078413		
Date Assigned:	04/29/2015	Date of Injury:	09/29/2003
Decision Date:	05/28/2015	UR Denial Date:	04/22/2015
Priority:	Standard	Application Received:	04/23/2015

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: New Jersey, Alabama, California
Certification(s)/Specialty: Neurology, Neuromuscular 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 46 year old female, who sustained an industrial/work injury on 9/29/03. She reported initial complaints of back pain. The injured worker was diagnosed as having displacement of lumbar intervertebral disc without myelopathy, spinal stenosis of lumbar spine, sciatica, sprains/strains of lumbosacral area. Treatment to date has included medication, diagnostics, and emergent surgery (cauda equine syndrome surgery on 1/6/15), and pain infusion pump. MRI results were reported on 4/6/15. CT Scan results were reported on 11/29/13. Currently, the injured worker complains of worsening back pain with radiculopathy. Per the primary physician's progress report (PR-2) on 4/8/15, gait was antalgic, moderately positive straight leg raise on the right. The requested treatments include Hot/Cold Therapy Unit W/Wrap, Purchase.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hot/Cold Therapy Unit W/Wrap, Purchase: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-328. Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back, Lumbar & Thoracic (acute & chronic).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Cold/heat packs.(http://www.worklossdatainstitute.verioiponly.com/odgtwc/low_back.htm#SPECT).

Decision rationale: According to ODG guidelines, cold therapy is "Recommended as an option for acute pain. At-home local applications of cold packs in first few days of acute complaint; thereafter, applications of heat packs or cold packs. (Bigos, 1999) (Airaksinen, 2003) (Bleakley, 2004) (Hubbard, 2004) Continuous low-level heat wrap therapy is superior to both acetaminophen and ibuprofen for treating low back pain. (Nadler 2003) The evidence for the application of cold treatment to low-back pain is more limited than heat therapy, with only three poor quality studies located that support its use, but studies confirm that it may be a low risk low cost option. (French-Cochrane, 2006) There is minimal evidence supporting the use of cold therapy, but heat therapy has been found to be helpful for pain reduction and return to normal function. (Kinkade, 2007) See also Heat therapy; Biofreeze cryotherapy gel." There is no evidence to support the efficacy of hot and cold therapy in this patient. There is not enough documentation relevant to the patient work injury to determine the medical necessity for cold therapy. There are no controlled studies supporting the use of hot/cold therapy in back pain. Therefore, the request for Hot/Cold Therapy Unit W/Wrap, Purchase is not medically necessary.