MAXIMUS Federal Services

Case Number:	CM15-0094302		
Date Assigned:	05/20/2015	Date of Injury:	06/25/2013
Decision Date:	06/24/2015	UR Denial Date:	04/20/2015
Priority:	Standard	Application Received:	05/15/2015

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:

The injured worker is a 57-year-old female who sustained an industrial injury on 6/25/13. Injury occurred when she attempted to block a special needs child from running off. Conservative treatment had included activity modification, ice pack, physical therapy, home exercise, medications, back brace, and epidural steroid injection. The 1/6/15 lumbar spine x-rays documented moderate collapse of the L4/5 segment with a 10-12 mm degenerative spondylolisthesis. The 1/16/15 lumbar spine MRI impression documented moderate diffuse degenerative disc disease with multilevel broad-based disc bulging and degenerative anterolisthesis at L4/5. There was mild right sided neuroforaminal narrowing at L5/S1 and mild to moderate neuroforaminal narrowing at L4/5. There was no significant canal or lateral recess stenosis. The 4/7/15 treating physician report cited progress low back pain radiating into the right leg with numbness and weakness. She had a right antalgic gait and some difficulty with heel walking on the right. There was limited and painful lumbar range of motion. Physical exam documented trace right extensor hallucis longus and ankle dorsiflexion weakness, diminished sensation over the right dorsal foot, and diminished and symmetrical reflexes. The diagnosis was spondylolisthesis, stenosis, sciatica, and lumbar strain. She had failed extensive conservative treatment and was a reasonable candidate for anterior retroperitoneal discectomy, open reduction and fusion at L4/5, followed by wide lam on the right side to decompress the right L4/5 foramen. The 4/20/15 utilization review certified a request for anterior L4/5 lumbar interbody fusion and posterior lumbar laminectomy/laminotomy. The request for purchase of a hot/cold therapy unit with wrap was non-certified as guidelines supported heat or cold packs and there was no

indication why she would be unable to utilize standard heat and cold packs rather than a hot/cold therapy unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

Associates Surgical Services: Purchase of Hot/Cold Therapy Unit with wrap: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Low Back, cold/heat packs.

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.