

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Notice of Independent Medical Review Determination

Dated: 12/10/2013

[REDACTED]

[REDACTED]

PO Box 660
Pomona, CA 91766

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	8/12/2013
Date of Injury:	5/17/2011
IMR Application Received:	8/27/2013
MAXIMUS Case Number:	CM13-0017547

- 1) MAXIMUS Federal Services, Inc. has determined the request for **DME: cold therapy unit** is not medically necessary and appropriate.

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/27/2013 disputing the Utilization Review Denial dated 8/12/2013. A Notice of Assignment and Request for Information was provided to the above parties on 10/11/2013. A decision has been made for each of the treatment and/or services that were in dispute:

- 1) MAXIMUS Federal Services, Inc. has determined the request for **DME: cold therapy unit** is not **medically necessary and appropriate**.

Medical Qualifications of the Expert Reviewer:

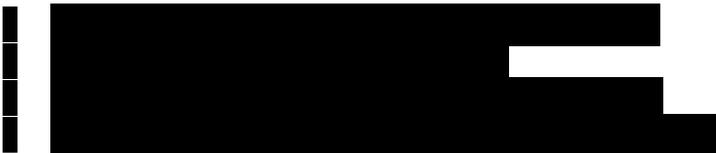
The independent Medical Doctor who made the decision has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Neuromuscular Medicine and is licensed to practice in California. 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 treatments and/or services at issue.

Expert Reviewer Case Summary:

The patient is a 43 year old male who apparently sustained an industrial-related injury on 05/17/2011 involving his Low Back. He underwent evaluation by a physician on 08/08/2013 and was diagnosed with: Lumbar Radiculitis; Lumbar Facet Arthropathy; and History of Left ChesVRib Sarcoma WIResection. The patient underwent a facet rhizotomy at the bilateral L4-S1 level. A cold therapy unit with moist heat has been requested for use after the interventional pain management procedure. This was denied on past due to now duration specified on request and also guidelines do not carry a recommendation for continuous-flow cryotherapy units used in the context of the lumbar spine.

Documents Reviewed for Determination:

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:



- 1) **Regarding the request for DME: cold therapy unit :**

The Medical Treatment Guidelines Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Official Disability Guidelines, Treatment Guidelines, Cold/Heat Packs, which is not part of the MTUS.

The Expert Reviewer found that no section of the MTUS was applicable. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Expert Reviewer based his/her decision on Official Disability Guidelines, Cold/Heat Packs, which is not part of the MTUS.

Rationale for the Decision:

The guidelines indicate ice/heat 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-Coclrane, 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). **The request for DME: cold therapy unit is not medically necessary and appropriate.**

Effect of the Decision:

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the final determination of the Administrative Director, Division of Workers' Compensation. With respect to the medical necessity of the treatment in dispute, this determination is binding on all parties.

In accordance with California Labor Code Section 4610.6(h), a determination of the administrative director may be reviewed only if a verified appeal is filed with the appeals board for hearing and served on all interested parties within 30 days of the date of mailing of the determination to the employee or the employer. The determination of the administrative director shall be presumed to be correct and shall be set aside only upon proof by clear and convincing evidence of one or more of the grounds for appeal listed in Labor Code Section 4610.6(h)(1) through (5).

Sincerely,

[Redacted]
Medical Director

cc: [Redacted]

/amm

Disclaimer: MAXIMUS is providing an independent review service under contract with the California Department of Industrial Relations. MAXIMUS is not engaged in the practice of law or medicine. Decisions about the use or nonuse of health care services and treatments are the sole responsibility of the patient and the patient's physician. MAXIMUS is not liable for any consequences arising from these decisions.