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**Notice of Independent Medical Review Determination**

Dated: 9/24/2013

[REDACTED]

[REDACTED]

[REDACTED]

Employee:

Claim Number:

Date of UR Decision:

Date of Injury:

IMR Application Received:

MAXIMUS Case Number:

[REDACTED]  
7/9/2013

3/8/2011

7/16/2013

CM13-0001660

- 1) MAXIMUS Federal Services, Inc. has determined the request for ThermaCool hot/cold contrast therapy with compression **is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/16/2013 disputing the Utilization Review Denial dated 7/9/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/19/2013. 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 ThermaCool hot/cold contrast therapy with compression **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 Occupational 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.

### **Case Summary:**

Disclaimer: The following case summary was taken directly from the utilization review denial/modification dated July 9, 2013

“History of Condition: The claimant is a 52-year-old female who sustained injury to her shoulders as well as cervical spine and lumbar spine on 3/8/2011. The exact mechanism of injury is not available for review. Treatments have included physical therapy, chiropractic treatment as well as Right shoulder surgery. According to recent progress report dated 6/27/13, patient continues to have low back pain as her main complaint. Pain radiates to the right lower extremity. Pain interferes with activities of daily living. On 11/28/12, patient had a right-sided L5-S1transforaminal epidural steroid injection that did give her 70-80% relief for 5 months. She stated pain was a lot better. Patient was able to walk more, take less medication and function better. Pain has now returned and is unbearable. Physical examination lumbar spine: flexion 45, extension 15, lateral flexion to the right and left 15 and rotation is 35°. Patient is tenderness at L4-5 and L5-S1. This is mainly over the facet. Diagnosed impression lumbar spine sprain/strain lumbar radiculopathy. The current request is for a hot/cold therapy with compression. This request is for 60 days. Current medications are not documented.”

### **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:

- Application for Independent Medical Review (dated 7/15/13)
- Utilization Review from [REDACTED] (dated 7/9/13)
- Medical records from the Claims Administrator (dated 6/18/12 – 6/27/12)

- Medical records from the employee's designated agent (Dated 4/03/13 – 6/26/13)
- Medical Treatment Utilization Schedule

**1) Regarding the request for ThermaCool hot/cold contrast therapy with compression:**

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the American College of Occupational and Environmental Medicine (ACOEM), 2<sup>nd</sup> Edition, update 2007, Chapter 12, Low Back, pg. 155, part of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found that the guidelines used by the Claims Administrator were not appropriate for the employee's clinical circumstance. The employee's clinical condition was described as low back pain; however, based on the findings of the treating provider, the employee's clinical condition is more appropriately described as chronic pain. The American College of Occupational and Environmental Medicine (ACOEM), 2<sup>nd</sup> Edition, update 2007, Chapter 12, Low Back, pg. 155 does not specifically address the issue at dispute; therefore the Expert Reviewer used the American College of Occupational and Environmental Medicine (ACOEM) Guidelines, Chapter 6, Chronic Pain, a medical treatment guideline, not part of the MTUS.

Rationale for the Decision:

The employee was injured on 3/08/2011 in a trip and fall incident. The medical records submitted for review document diagnoses of lumbar spine strain/sprain, low back pain with radicular symptoms to the right lower extremity, and Adjustment Disorder with Depression and Anxiety. Medical records indicate treatment has included at least two epidural steroid injections which provided significant relief, with 70% reduced pain for five months reported, however the employee is still experiencing intractable pain. A request has been submitted for ThermaCool hot/cold contrast therapy with compression.

ACOEM Guidelines Chapter 6, Chronic Pain, state that there is no recommendation for or against the use of cryotherapies for treatment of chronic persistent pain. However, the guidelines state there is some evidence of efficacy for self-applications of low-tech heat/cold therapy (water bottle or heated towel) for flare-ups with a primary emphasis on functional restoration elements such as exercise. The medical records reviewed do not provide sufficient evidence to support the use of a ThermaCool device over self-application of low/no-cost home heat and cold therapies. The request for ThermaCool hot/cold contrast therapy with compression is not medically necessary.

**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;

Richard C. Weiss, MD, MPH, MMM, PMP  
Medical Director

cc: Department of Industrial Relations  
Division of Workers' Compensation  
1515 Clay Street, 18<sup>th</sup> Floor  
Oakland, CA 94612

/srb

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.