

Case Number:	CM13-0028335		
Date Assigned:	11/27/2013	Date of Injury:	05/09/2007
Decision Date:	02/17/2014	UR Denial Date:	09/19/2013
Priority:	Standard	Application Received:	09/23/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Family Practice 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient reported an injury on 05/09/2007 due to lifting a patient. The patient's treatment history included multiple surgical interventions, epidural steroid injections, and a functional restoration program. The patient's most recent clinical documentation notes that the patient has continued low back pain that is increased by prolonged activities. Physical findings included lumbar lordosis due to L2 through S1 fusion with no evidence of lumbosacral tenderness, a negative compression test, a negative distraction test, a negative Patrick-Fabere test, a negative Gaenslen's test, a negative Gillet test, and a negative Yeoman's test. The patient's diagnoses included a lumbar sprain/strain, history of lumbar fusion, and lumbar spine/left lower radiculopathy. The patient's treatment plan included additional epidural steroid injections and the replacement of the patient's home cooling device.

IMR ISSUES, DECISIONS AND RATIONALES

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

Iceman Cooling Device: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines ((ODG)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Hot/Cold Packs and Shoulder Chapter, Continuous Flow Cryotherapy

Decision rationale: The requested Iceman Cooling Device is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient was previously dispensed a cooling device. It is noted that the patient uses this to self manage pain symptoms. It is also noted that the patient's device is no longer functional and would need replacement. Official Disability Guidelines do not recommend continuous flow cryotherapy units in the absence of surgical intervention. The clinical documentation submitted for review does not provide any evidence that the patient has had any recent surgical intervention. Additionally, adequate evaluation of the patient's usage of this equipment is not provided. There is no documentation that the patient has significant functional benefit from its usage. There is no evaluation or determination of how often it is used. Therefore, the efficacy of this treatment modality cannot be determined. As such, the requested Iceman Cooling Device is not medically necessary or appropriate.