

Case Number:	CM13-0054895		
Date Assigned:	12/30/2013	Date of Injury:	09/22/2011
Decision Date:	04/14/2014	UR Denial Date:	11/01/2013
Priority:	Standard	Application Received:	11/20/2013

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. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation, has a subspecialty in Interventional Spine 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 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 is a 49 year-old male with a date of injury of 09/22/2011. The listed diagnoses per [REDACTED] dated 10/17/2013 are: 1) Lumbar spine degenerative disc disease at L1-L5 with posterior bulging of discs at L3-S1 2) Bilateral sacroiliac joint arthropathy 3) Lumbar spine spondylosis 4) Lumbosacral paraspinal muscle spasm. According to report dated 10/17/2013 by [REDACTED], the patient presents with low back pain. He reports there is improvement in his headaches, which happened secondary to epidural steroid injections. He also continues to complain of right knee and right ankle pain. Examination of the lumbar spine reveals tenderness over the lumbar paraspinal region bilaterally. There is tenderness and muscle spasm noted on right and left. Straight left raise produces leg pain in the sitting position on the right. FABERE is positive bilaterally. Range of motion is decreased on all planes.

IMR ISSUES, DECISIONS AND RATIONALES

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

[REDACTED] **HOT AND COLD CONTRAST THERAPY WITH COMPRESSION:**

Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee and Leg Chapter: Continuous-flow cryotherapy

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Continuous-Flow Cryotherapy

Decision rationale: This patient presents with chronic back pain. The treater is requesting a [REDACTED] cold/hot contrast therapy unit for 60 days for pain control, reduction of inflammation and increased circulation. The MTUS and ACOEM guidelines do not discuss Cold/hot Therapy units specifically. However, the ODG guidelines have the following regarding continuous-flow cryotherapy: "Recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage; however, the effect on more frequently treated acute injuries (e.g., muscle strains and contusions) has not been fully evaluated." In this case, ODG guidelines do not support this type of device other than for post-operative recovery, which does not apply to this patient. The request is not medically necessary and recommendation is for denial.