

<b>Case Number:</b>	CM13-0068791		
<b>Date Assigned:</b>	06/13/2014	<b>Date of Injury:</b>	02/01/2000
<b>Decision Date:</b>	08/20/2014	<b>UR Denial Date:</b>	11/27/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/19/2013

### 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 & Rehab 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 injured worker is a 55-year-old male who reported an injury on 02/01/2000 after he hit a truck while driving a forklift. The injured worker reportedly sustained an injury to his low back. The injured worker's treatment history included medications, physical therapy, back brace, epidural steroid injections, and facet blocks. The injured worker was evaluated on 10/23/2013. Physical findings included a positive straight leg raising test bilaterally with restricted range of motion secondary to pain. The injured worker's diagnoses included degenerative lumbar intervertebral disc disease, low back pain, displacement of a lumbar intervertebral disc without myelopathy, radiculopathy, and sciatica. The injured worker's treatment plan included decompression and fusion at the L5-S1. This request included postsurgical care to include a motorized cold therapy unit for a 2 week rental.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**MOTORIZED COLD THERAPY UNIT - 2 WEEKS RENTAL:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Cold/Heat Packs.

**Decision rationale:** The requested MOTORIZED COLD THERAPY UNIT - 2 WEEKS RENTAL is not medically necessary or appropriate. The clinical documentation submitted for review does indicate that the injured worker is a surgical candidate. However, there is no indication that surgery has been authorized or is scheduled. Additionally, the Official Disability Guidelines recommend hot and cold applications be performed manually. Continuous flow cryotherapy units are reserved for major joints such as shoulders and knees. Furthermore, the requested 2 weeks what would typically be considered a normal duration of use of 7 days. There are no exceptional factors noted within the documentation to support extending treatment beyond Guideline recommendations. As such, the requested MOTORIZED COLD THERAPY UNIT - 2 WEEKS RENTAL is not medically necessary or appropriate.