

<b>Case Number:</b>	CM14-0012100		
<b>Date Assigned:</b>	02/21/2014	<b>Date of Injury:</b>	05/01/2012
<b>Decision Date:</b>	07/03/2014	<b>UR Denial Date:</b>	01/10/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/30/2014

### 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 Pain Medicine and is licensed to practice in Minnesota. 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 49 year old male who reported an injury on 05/01/2012 due to an unknown mechanism of injury. The injured worker reported pain in the neck, right wrist, and lower back. On physical examination dated 12/10/2013, the injured worker had tenderness over C5-6 and C6-7 bilaterally. On 6/18/2012 an MRI revealed mild posterior bulges at L3-L4, L4-L5 and L5-S1. The injured worker had diagnoses of cervical spine sprain, right wrist sprain, and lumbar spine sprain. The injured worker was taking Ultracet 37.5/325mg, Relafen 500mg, Xanax 0.25mg, and Amitryptiline/Tramadol/Dextromethorphan compound for pain. The current treatment plan was for retro cold water circulating unit. The request for authorization form was not provided for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**RETRO COLD WATER CIRCULATING UNIT (PURCHASE):** 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), KNEE & LEG, CONTINUOUS- FLOW CRYOTHERAPY.

**Decision rationale:** The request for retro cold circulating unit is not medically necessary. The Official Disability Guidelines (ODG) recommends a cold circulating unit as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. There is no documentation provided that would indicate that the injured worker has had any type of surgical treatment or procedure. Since the use of a cryotherapy unit is indicated for postoperative use, the request for the purchase of a cryotherapy unit is not supported. In addition, the request for the purchase of a cryotherapy unit exceeds guideline recommendations of up to 7 days of use. Given the above, the request for a retro cold water circulating unit is not medically necessary.

**LUMBAR HOME EXERCISE KIT (PURCHASE):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Exercise.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Exercise Page(s): 127-128.

**Decision rationale:** The request for the lumbar home exercise kit is non-certified. The CA MTUS guidelines state that there is no sufficient evidence to support the recommendation of any particular exercise regimen over any other exercise regimen. The research and evidence in regards to the effectiveness of the lumbar home exercise kit is unclear. Since the guidelines cannot recommend one exercise program over another, the use of a home exercise kit cannot be recommended over a basic home exercise program. Therefore, the request for the lumbar home exercise kit is non-certified.