

<b>Case Number:</b>	CM14-0113950		
<b>Date Assigned:</b>	08/01/2014	<b>Date of Injury:</b>	10/03/2013
<b>Decision Date:</b>	09/10/2014	<b>UR Denial Date:</b>	07/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/21/2014

### 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 and Rehabilitation, has a subspecialty in pain 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 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 32 year old male who sustained an injury to his low back on 10/03/13. The progress note dated 05/30/14 reported that the injured worker complained of intermittent, moderate, dull pain and stiffness at 5/10 visual analogue scale (VAS), aggravated with movement, better with resting. Physical examination noted cranial nerves 2-12 within normal limits; fingertip to fingertip and fingertip to nose performed normally; no bruising, swelling, atrophy or lesion present in the lumbar spine; range of motion flexion 60 degrees, extension 115 degrees, left lateral bending 15 degrees, right lateral bending 15 degrees; tenderness to palpation of the lumbar paravertebral musculature. MRI of the lumbar spine was reported negative. The injured worker was diagnosed with lumbar sprain/strain, thoracic sprain/strain, left shoulder sprain/strain, and headache.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Hot/Cold Therapy Unit rental for 6 weeks:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM and (ODG) Official Disability Guidelines.

**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 previous request was denied on the basis that motorized thermal units are only guideline supported for temporary use in the post-operative period. Otherwise, hot and cold packs may be utilized for thermal modalities. There was no information provided that would indicate the need for the requested modality. There was no indication as to why the injured worker could not produce the same effect with traditional hot/cold packs and ace wraps for compression. Therefore, the request for hot/cold therapy unit rental for six weeks is not indicated as medically necessary.