

<b>Case Number:</b>	CM14-0118566		
<b>Date Assigned:</b>	08/06/2014	<b>Date of Injury:</b>	07/24/2012
<b>Decision Date:</b>	09/24/2014	<b>UR Denial Date:</b>	06/26/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/29/2014

### 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 Occupational 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 patient is a 55-year-old female who has submitted a claim for chronic low back pain with radicular symptoms to the right L4-5 distribution, lumbar spine sprain/strain, and lumbar spine degenerative disc disease associated with an industrial injury date of 07/24/2012. Medical records from 11/21/2013 to 06/26/2014 were reviewed and showed that patient complained of low back pain graded 3-4/10 with radicular symptoms to the right lower extremity with associated numbness and tingling. Physical examination revealed MMT of 4 to 4+/5 in the right lower extremity, decreased sensation along right L4 and L5 dermatomal distribution, and positive SLR test on the right. MRI of the lumbar spine dated 10/09/2012 revealed modest spondylitic annular prominence at thoracolumbar junction and right annular protrusion dislocates right S1 root in lateral recess. Treatment to date has included lumbar ESI, bilateral L5-S1 and right L4-5 (04/08/2013), chiropractic care, physical therapy, and oral and topical pain medications. Utilization review dated 06/26/2014 denied the request for post injection: motorized cold therapy unit purchase because there was minimal evidence supporting the use of cold therapy for low back pain.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Post Injection: Motorized Cold Therapy Unit Purchase: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guideline (ODG) Low Back Chapter.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Aetna Clinical Policy Bulletin: Cryoanalgesia and Therapeutic Cold.

**Decision rationale:** The CA MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, Aetna was used instead. The Aetna Clinical Policy Bulletin considers passive cold compression therapy units experimental and investigational for all other indications because their effectiveness for indications has not been established. The use of hot/ice machines and similar devices are experimental and investigational for reducing pain and swelling after surgery or injury. Studies failed to show that these devices offer any benefit over standard cryotherapy with ice bags/packs. In this case, the patient complained of chronic low back pain with radicular symptoms to the right lower extremity with associated numbness and tingling. A post injection request for motorized cold therapy unit was made. However, the guidelines do not recommend ice/cold machine units as they have not been proven to be superior over standard cryotherapy. It is unclear as to why conventional cold pack application will not suffice. Therefore, the request for Post Injection: Motorized Cold Therapy Unit Purchase is not medically necessary.