

Case Number:	CM14-0135346		
Date Assigned:	08/29/2014	Date of Injury:	05/01/2013
Decision Date:	11/05/2014	UR Denial Date:	07/25/2014
Priority:	Standard	Application Received:	08/22/2014

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 Internal 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 23-year-old male, who reported injury on 05/01/2013. The mechanism of injury was not provided. The injured worker's diagnoses included sprain/strain of the thoracic, cervical, lumbar spine and bilateral shoulder. The injured worker's diagnostic testing was not provided. The injured worker's surgical history included epidural decompression neuroplasty of the lumbar nerve roots bilaterally at L2-S1 on 05/27/2014. The injured worker's medication was not provided. The injured worker's past treatments include physical and manipulating therapy, acupuncture, injections, and prescribed medications. The injured worker also received shockwave therapy treatment sessions for the cervical spine, thoracic spine, and lumbar spine. On the clinical note dated 02/11/2014, the injured worker complained of lumbar pain rated 8/10, thoracic pain rated 8/10, cervical pain rated 8/10, and bilateral shoulder pain rated 4/10. The injured worker had decreased range of motion with pain to the cervical spine. The request was for a cold therapy unit. The rationale for the request was not provided. The Request for Authorization form was not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cold Therapy Unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS.
Decision based on Non-MTUS Citation LOW BACK, COLD/HEAT PACKS

Decision rationale: The request for cold therapy unit is not medically necessary. The injured worker is diagnosed with sprain/strain of the thoracic, cervical, lumbar spine and bilateral shoulder. The injured worker complained of pain to the cervical, thoracic, and lumbar spine rated 8/10 and bilateral shoulder rated 4/10. The Official Disability Guidelines recommend cold/heat packs as an option for acute pain (at home local applications of cold packs in the first few days of acute complaint, thereafter applications of heat packs or cold packs). Continuous low level heat wrap therapy is superior to both acetaminophen and ibuprofen for treating low back pain. The evidence for the application of cold treatment to low back pain is more limited than heat therapy, with only 3 poor quality studies located that support its use, but studies confirm that it may be a low risk, low cost option. The request does not indicate the rationale for the cold therapy unit. Additionally, there is a lack of documentation of the injured worker's conservative care. The request does not indicate the body part on which the cold therapy unit is to be applied or the frequency of usage. As such, the request for cold therapy unit is not medically necessary.