

<b>Case Number:</b>	CM14-0137977		
<b>Date Assigned:</b>	09/05/2014	<b>Date of Injury:</b>	04/17/2008
<b>Decision Date:</b>	10/14/2014	<b>UR Denial Date:</b>	08/01/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/26/2014

### 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 Family 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 39 year old male whose date of injury is 04/17/08. The mechanism of injury is not described. Treatment to date includes L4-5 disc replacement surgery on 04/13/10, left piriformis muscle release surgery on 02/10/12, posterior fusion at L4-5 on 02/12/13, lumbar epidural steroid injections, acupuncture, and medication management. The injured worker was authorized for a 3 month trial of Polar care unit in August. Diagnoses are posterior fixation with interbody disc replacement at L4-5 with posterolateral bone fusion; L2-3 2-3 mm disc protrusion with focal peripheral annular tear; neuropathic pain bilateral lower extremities; status post L4-5 disc replacement surgery; L3-4 bilateral neural foraminal encroachment; status post left piriformis muscle release surgery; and status post L4-5 posterior fusion.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Polar care unit QTY: 6.00 (in months):** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Low Back Chapter, Cold/heat

**Decision rationale:** Based on the clinical information provided, the request for Polar care unit qty 6 months is not recommended as medically necessary. There is no support for cryotherapy in the Official Disability Guidelines Low Back Chapter. The injured worker was authorized for Polar care unit for 3 months in August; however, the injured worker's response to this treatment is not documented. There is no clear rationale provided to support the requested unit, and the Official Disability Guidelines would support the at-home local application of cold packs. Therefore, this request is not medically necessary.