

<b>Case Number:</b>	CM14-0061751		
<b>Date Assigned:</b>	07/11/2014	<b>Date of Injury:</b>	01/10/1997
<b>Decision Date:</b>	08/13/2014	<b>UR Denial Date:</b>	04/02/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/02/2014

### 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 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 55-year-old male who reported an injury on 01/10/1997 caused by an unspecified mechanism. The injured worker's treatment history included medications and back surgery. On 03/12/2014, it was documented that the injured worker had a seizure in the emergency waiting room and he fell to the left side injuring his left wrist and had increased low back pain. It was noted that the emergency room told him to followup with his primary treating physician regarding his left wrist and increased left back pain. The injured worker was evaluated on 05/19/2014, and it was documented that injured worker complained of constant low back pain that radiates into the lower extremities which has not been reduced with epidural injections, cervical spine pain, continued hearing loss due to prolonged medication use, depression, anxiety, and stress. The physical examination of the cervical and lumbar spine revealed difficulty with all areas of body movement. Range of motion of the cervical spine was left/right lateral flexion 30 degrees and extension 20 degrees, flexion 10 degrees. There was palpation and paraspinal spasms right/left of the paraspinal musculature and anterior scalene muscles. The cervical spine orthopedic tests revealed foraminal compression test, shoulder decompression test, and shoulder depression test were all positive on the right and left. There were no medications listed for the injured worker. The diagnoses included status post lumbar spine surgery x3 with 360 flip lumbar spine fusion from L3-S1, cervical spine intervertebral disc herniation with radiculopathy to bilateral upper extremities, hearing loss, decaying teeth and pain due to prolonged medication use, status post penile implant, severe depression, suicide ideations, anxiety, stress, sleep deprivation and apnea, bilateral carpal tunnel release, and severe hypertension. The request for authorization or rationale was not submitted for this review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Cold therapy unit cervical, lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines, low back, cryotherapy.

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

**Decision rationale:** The request for cold therapy unit cervical, lumbar spine is not medically necessary. CA MTUS/ACEOM state that physical modalities such as massage, diathermy, cutaneous laser treatment, ultrasound, transcutaneous electrical neurostimulation (TENS) units, percutaneous electrical nerve stimulation (PENS) units, and biofeedback have no proven efficacy in treating acute low back symptoms. Insufficient scientific testing exists to determine the effectiveness of these therapies, but they may have some value in the short term if used in conjunction with a program of functional restoration. Insufficient evidence exists to determine the effectiveness of sympathetic therapy, a noninvasive treatment involving electrical stimulation, also known as interferential therapy. At home local applications of heat or cold are as effective as those performed by therapists. The documentation submitted on 05/19/2014 indicated the injured worker's instability following his back surgery; however, there was a lack of documentation submitted when the injured worker had his back surgery. In addition, the request did not include duration of usage for the cold therapy cervical unit. Therefore, the request is not medically necessary.