

Case Number:	CM14-0109323		
Date Assigned:	08/01/2014	Date of Injury:	08/18/2011
Decision Date:	01/28/2015	UR Denial Date:	06/10/2014
Priority:	Standard	Application Received:	07/14/2014

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 Rehab, 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 33-year old male with date of injury 8/18/11. The treating physician report dated 5/13/14 (24) indicates that the patient presents with left-sided lower back pain that is sharp with an intensity of 8/10. The physical examination findings reveal the patient has tenderness over the L4-L5, L5-S1 facet area mainly on the left side with facet loading being positive for pain in the lower lumbar region. Prior treatment history includes a diagnostic facet block in the lumbar area on the left side at the level of L4-L5 and L5-S1, which provided 80% relief for at least two hours after which the pain gradually returned. The current diagnoses are: - Lumbar spine sprain/strain - Axial lower back pain - L5-S1 disc protrusion - Facet arthropathy, L4-L5, L5-S1 bilaterally. The utilization review report dated 6/10/14 denied the request for Motorized Cold Therapy Unit Purchase based on MTUS/ACOEM Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Motorized Cold Therapy Unit Purchase: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation 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 - Lumbar & Thoracic, cold/heat packs.

Decision rationale: The patient presents with left-sided lower back pain that is sharp with an intensity of 8/10. The patient has been approved for radiofrequency ablation of the facet joints in the lumbar area on the left side at L4-L5 and L5-S1. The current request is for Motorized Cold Therapy Unit, purchase. The treating physician report dated 5/13/14 (24) states, "I would like to order the following for the patient to be utilized post injection: Motorized Cold Therapy Unit for purchase only." ODG guidelines state that "at-home local applications of cold packs in first few days of acute complaint; thereafter, applications of heat packs or cold packs. The evidence for the application of cold treatment to low-back pain is more limited than heat therapy, with only three poor quality studies located that support its use, but studies confirm that it may be a low risk low cost option. There is minimal evidence supporting the use of cold therapy, but heat therapy has been found to be helpful for pain reduction and return to normal function." In this case, the treating physician has requested a motorized cold therapy unit for purchase and has not explained why the application of an ice packs at home would not suffice if cryotherapy was required. The ODG guidelines do recommend continuous-flow cryotherapy for patients up to 7 days post surgically following knee surgery. The ODG state that cold packs are appropriate for acute complaints and that there is minimal evidence supporting the use of cold therapy. The documents provided for review do not indicate that the patient has had knee surgery and ODG for Facet joint radiofrequency neurotomy does not indicate that motorized cold therapy is required following this procedure. The current request is not medically necessary.