

Case Number:	CM14-0146443		
Date Assigned:	09/12/2014	Date of Injury:	06/29/2006
Decision Date:	01/23/2015	UR Denial Date:	08/29/2014
Priority:	Standard	Application Received:	09/09/2014

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:

This is a 58-year-old female with a 6/29/06 date of injury. She was working as a nursing assistant, turning a patient over, when she sustained acute strains to the cervical, thoracic, and lumbar spine. According to a progress report dated 6/5/14, the patient complained of persistent pain in her mid-back and low back with numbness and weakness of the lower extremities. She rated the severity of her pain as an 8/10 without medication or therapy and was reduced to a 5/10 with medications only. She stated that acupuncture therapy had previously afforded her significant pain relief lasting 2 months. Objective findings: muscular spasm over the cervical spine region, no tenderness to palpation, stiffness of the facet joints associated with muscular guarding over the paraspinal musculature of the thoracolumbar spine, patient was unable to perform range of motion. Diagnostic impression: cervical spine HNP, thoracic spine HNP, lumbar spine HNP, stress, insomnia, rule out fibromyalgia, fatigue. Treatment to date: medication management, activity modification, acupuncture therapy. A UR decision dated 9/2/14 denied the request for motorized cold therapy. There is no acute indication of injury in this individual who is now greater than 8 years from the time of injury, and there is also no indication of acute surgical process in this individual that would support the acute need of cryotherapy. Given the claimant's diffuse and chronic musculoskeletal complaints, there would be no acute indication for the topical use of cryotherapy or cold treatment.

IMR ISSUES, DECISIONS AND RATIONALES

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

Motorized cold therapy: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 337-339.

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 (http://www.aetna.com/cpb/medical/data/200_299/0297.html)

Decision rationale: CA MTUS and ODG do not address this issue. Aetna considers the use of the Hot/Ice Machine and similar devices (e.g., the Hot/Ice Thermal Blanket, the TEC Thermoelectric Cooling System (an iceless cold compression device), the Vital Wear Cold/Hot Wrap, and the Vital Wrap) experimental and investigational for reducing pain and swelling after surgery or injury. Studies in the published literature have been poorly designed and have failed to show that the Hot/Ice Machine offers any benefit over standard cryotherapy with ice bags/packs; and there are no studies evaluating its use as a heat source. However, in the present case, there is no documentation of an acute condition, such as surgery or a recent injury, that would indicate that this modality of treatment is medically necessary. In addition, there is no documentation that this patient has tried and failed the use of standard cold/ice packs. A specific rationale as to why a cold therapy unit is indicated in this patient at this time was not provided. Therefore, the request for Motorized cold therapy was not medically necessary.