

<b>Case Number:</b>	CM14-0200613		
<b>Date Assigned:</b>	12/10/2014	<b>Date of Injury:</b>	11/27/2012
<b>Decision Date:</b>	01/28/2015	<b>UR Denial Date:</b>	11/08/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/01/2014

### 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, has a subspecialty in Interventional spine 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 63 year old male with an injury date of 11/27/12. As per progress report dated 09/19/14, the patient complains of severe pain in the lumbar spine, rated at 10/10, that radiates to the bilateral legs producing numbness and tingling. Standing or walking for any length of time worsens the pain. Physical examination of the lumbar spine reveals severely limited range of motion with flexion at 15 degrees. Straight leg raise led to severe pain in the low back and radicular pain in the L5 and S1 regions. Achilles reflex is reduced bilaterally. As per progress report dated 07/24/14, the patient's low back pain is rated at 8/10. The patient is diabetic as well. Physical examination reveals increased tone and tenderness in the paralumbar musculature along with tenderness at the midline thoracolumbar junction and over the level of L5-S1 facets and the right greater sciatic notch. The range of motion is limited and there are muscle spasms as well. Straight leg raise and Lasegue's test are positive on the left. Neurological evaluation reveals decreased sensation in left L5 and S1 distribution. Medications, as per progress report dated 09/19/14, include Tylenol # 3, Ibuprofen and Soma. The patient also received bilateral transforaminal epidural injection at L4-5 on 01/23/14, as per the operative report. The patient's work status has been determined as temporarily and totally disabled, as per progress report dated 09/19/14. MRI of the Lumbar Spine, 06/06/13, as per progress report dated 07/24/14:- Hemangioma are noted throughout the lumbar spine and are benign appearing- 3.4 mm broad posterior disc bulge with facet arthrosis and hypertrophy at L3-4 along with mild central canal and moderate bilateral foraminal narrowing.- Anterolisthesis of L4 on L5 by 10% of vertebral body length. 4.1 mm posterior pseudodisc bulge; pars hypertrophy and facet arthrosis; mild central canal and moderate bilateral foraminal narrowing; Effacement of perineural fat surrounding both exiting nerve roots X-ray of the Lumbar Spine, 07/17/14, as per progress report dated 07/17/14: - Diffuse spondylosis with large anterior and lateral osteophytes at L3-4 and L4-

5- Minimal spondylolisthesis at L4-5 with 5 mm of anterolisthesis of L4 on L5 X-ray of the Thoracic Spine, 07/17/14, as per progress report dated 07/17/14: Diffuse spondylosis and osteophyte formation. Diagnoses, 09/19/14:- Lumbar sprain/strain with probable herniated disc; facetogenic pain; radiculopathy primarily on the left with exacerbation secondary to fall and left radicular pain.- Anterolisthesis of L4 on L5 with central canal and foraminal narrowing at L4-L5 and L5-S1. The treater is requesting for POST-OPERATIVE CRYOTHERAPY. The utilization review determination being challenged is dated 11/08/14. Treatment reports were provided from 01/17/14 - 10/16/14.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Cryotherapy of skin:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. 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 (Acute & Chronic) Chapter, Cold/heat packs.

**Decision rationale:** The patient presents with severe pain in the lumbar spine, rated at 10/10, that radiates to the bilateral legs producing numbness and tingling. The request is for post-operative cryotherapy. MTUS does not discuss cold therapy and ODG guidelines do not discuss cold therapy following lumbar surgery. ODG under L-spine chapter, cold/heat section, supports cold therapy for acute pain. "At-home local applications of cold packs in first few days of acute complaint; thereafter, applications of heat packs or cold packs." Continuous flow cold therapy is supported for post-operative use following knee and shoulder surgeries for a short-term use. The current request and the UR letter say the request is for "Cryotherapy of Skin," but addresses post-op cryotherapy. The Request for Authorization form dated 11/04/14 says the request is for "post-op cryotherapy." In progress report dated 10/16/14, the treater states that the patient has been authorized to undergo L4-L5 and L5-S1 microdiscectomy left sided and hemilaminotomy and foraminotomy decompression. The request, as per the report, is for "a course of post-operative cryotherapy at a rate of twice a week for 4 weeks as well as a course of post-operative physical therapy at a rate of twice a week four weeks." In this case, while post-operative therapy is appropriate, the treater does not define what cryotherapy he is referring to. ACOEM and ODG guidelines support at-home application of cold/heat, and a use of ice bag may be all that is needed. If the treater is referring to a continuous flow cold therapy unit, then this is not discussed for Lumbar spine but for knee and shoulder only per ODG. The request is not medically necessary.