

Case Number:	CM15-0008094		
Date Assigned:	01/23/2015	Date of Injury:	01/14/2013
Decision Date:	03/17/2015	UR Denial Date:	12/10/2014
Priority:	Standard	Application Received:	01/14/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: New Jersey, Michigan, California
 Certification(s)/Specialty: Neurology, Neuromuscular Medicine

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 50 year old male, who sustained an industrial injury on 1/14/13. He has reported pain in the shoulder, neck and upper back. The diagnoses have included shoulder sprain, umbilical hernia and right sacroiliac joint arthropathy. Treatment to date has included diagnostic studies, cortisone injections and oral medications. As of the PR2 dated 12/18/14, the injured worker reported constant low back pain with radiation to right leg. The injured worker is waiting for authorization for sacroiliac joint injections. The treating physician is requesting purchase of a motorized cold therapy unit. On 12/10/15 Utilization Review non-certified a request for a purchase of a motorized cold therapy unit. The UR physician cited the ODG guideline chapters on low back and knee cryotherapy. On 1/5/15, the injured worker submitted an application for IMR for review for a purchase of a motorized cold therapy unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

Motorized Cold Therapy Unit: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Workers' Compensation Low Back-Lumbar & Thoracic

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Cold/heat packs.(http://www.worklossdatainstitute.verioiponly.com/odgtwc/low_back.htm#SPECT).

Decision rationale: According to ODG guidelines,cold therapy is "Recommended as an option 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. (Bigos, 1999) (Airaksinen, 2003) (Bleakley, 2004) (Hubbard, 2004) Continuous low-level heat wrap therapy is superior to both acetaminophen and ibuprofen for treating low back pain. (Nadler 2003) 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. (French-Cochrane, 2006) 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. (Kinkade, 2007) See also Heat therapy; Biofreeze cryotherapy gel." There is no evidence to support the efficacy of hot and cold therapy in this patient. There sacroiliac joint injection request was not authorized, subsequently, the request for Motorized Cold Therapy Unit post injection is not medically necessary.