

<b>Case Number:</b>	CM15-0101442		
<b>Date Assigned:</b>	06/03/2015	<b>Date of Injury:</b>	04/26/2013
<b>Decision Date:</b>	07/09/2015	<b>UR Denial Date:</b>	05/07/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/27/2015

### 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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

### 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 58-year-old male who sustained an industrial injury on April 26, 2013. He has reported lower back pain and has been diagnosed with lumbosacral musculoligamentous strain/sprain with radiculitis and multiple disc protrusions with intervertebral foraminal /spinal stenosis. Treatment has included medications, modified work duty, medical imaging, injections, and acupuncture. Objective findings noted the injured worker ambulates with antalgic gait favoring the right lower extremity. He had problems moving onto and off the examination table without assistance. He had tenderness to palpation to the bilateral frontal area. There was lumbar spine tenderness to palpation bilateral paraspinal muscles/sacroiliac joints/sciatic notch/posterior iliac crests/gluteal muscles, spasms bilateral paraspinal muscles/gluteal muscles, decreased range of motion, positive straight leg raise. There was decreased deep tendon reflexes to bilateral knees/ankles at 1+/2+; decreased motor strength bilateral lower extremities at 4/5. There was decreased sensation right anterolateral thigh/ anterior knee/medial leg and foot. The treatment request included a hot/cold therapy unit.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Hot/Cold Therapy Unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Integrated Treatment/Disability Duration Guidelines, Low Back- Lumbar & Thoracic (Acute & Chronic), Online Version updated 4/29/15, cold/heat packs.

**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 Chapter, Cryotherapy, Cold/Heat Packs.

**Decision rationale:** Regarding the request for hot/cold therapy unit, California MTUS does not address the issue. ODG supports the use of continuous-flow cryotherapy for up to 7 days after surgery for some body parts, but not for non-surgical use. For the low back, the use of cold/heat packs are recommended. Within the documentation available for review, there is no rationale for the use of a specialized hot/cold therapy unit rather than the simple hot/cold packs recommended by the guidelines. In light of the above issues, the currently requested hot/cold therapy unit is not medically necessary.