

<b>Case Number:</b>	CM15-0149482		
<b>Date Assigned:</b>	08/12/2015	<b>Date of Injury:</b>	09/10/2011
<b>Decision Date:</b>	09/09/2015	<b>UR Denial Date:</b>	07/07/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/31/2015

### 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 42-year-old male with an industrial injury dated 09-10-2011. The injured worker's diagnoses include lumbar radiculopathy, herniation of the lumbar disc, and lumbar discogenic pain. Treatment consisted of MRI of lumbar spine, prescribed medications, chiropractic treatment, physical therapy and periodic follow up visits. In a progress note dated 06-24-2015, the injured worker's subjective complaints included neck, right shoulder, upper, middle and lower back. Objective findings revealed decreased lumbar range of motion with spasm and tenderness to palpitation. Bilateral sciatic notch tenderness, bilateral positive straight leg raises and decrease sensation in the bilateral L5 dermatomes were also noted on exam. The treatment plan consisted of medication management, lumbar epidural steroid injection (ESI), cold therapy unit and follow up visit. The treating physician prescribed services for post-injection motorized cold therapy unit for purchase only, now under review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Post-injection motorized cold therapy unit for purchase only: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines, Treatment in Workers Compensation, Low Back Procedure Summary.

**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 and Cold/heat packs.

**Decision rationale:** Regarding the request for cold therapy unit, CA MTUS does not address the issue. ODG recommends simple cold packs in the management of low back injuries. When cold therapy units are supported for other body parts, they are recommended only for postsurgical use and only for up to 7 days after surgery. Within the documentation available for review, there is no clear rationale for cold therapy despite the recommendations of the guidelines outlined above. In light of the above issues, the currently requested cold therapy unit is not medically necessary.