

<b>Case Number:</b>	CM15-0196673		
<b>Date Assigned:</b>	10/12/2015	<b>Date of Injury:</b>	05/27/2000
<b>Decision Date:</b>	11/19/2015	<b>UR Denial Date:</b>	10/05/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/06/2015

### 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: Preventive Medicine, Occupational 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:

This injured worker is a 54 year old female, who sustained an industrial injury on 05-27-2000. The injured worker was diagnosed as having spinal stenosis, lumbar, lumbosacral neuritis NOS, back disorder NOS, and chronic pain syndrome. On medical records dated 06-24-2015, 08-05-2015 and 09-30-2015, the subjective complaints were noted as low back pain. Objective findings were noted as antalgic gait, lumbar tenderness and spasm were noted. Lumbar spine range of motion was noted tested. Treatments to date included physical therapy, home exercise program, polar care unit and trigger point injections. The injured worker was noted to be temporary totally disabled. No pain scale was noted 09-30-2015. Current medications were not listed on 09-30-2015. The provider noted the injured worker was in need a of a replacement of polar care unit - lumbar pad. The Utilization Review (UR) was dated 10-05-2015. A Request for Authorization was dated 10-01-2015 one (1) lumbar pad for polar care unit was submitted. The UR submitted for this medical review indicated that the request for one (1) lumbar pad for polar care unit was non-certified.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**One (1) lumbar pad for polar care unit: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Physical Methods. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter/Cold/Heat Packs Section.

**Decision rationale:** MTUS guidelines support the use of at-home local applications of cold in first few days of acute complaint; thereafter, applications of heat or cold. The ODG supports the use of cold-packs 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. 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. There is no evidence that a commercially obtained ice or heat unit is superior to the at-home application of ice, therefore, the request for one (1) lumbar pad for polar care unit is determined to not be medically necessary.