

<b>Case Number:</b>	CM15-0208310		
<b>Date Assigned:</b>	10/27/2015	<b>Date of Injury:</b>	04/27/2015
<b>Decision Date:</b>	12/09/2015	<b>UR Denial Date:</b>	10/14/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/22/2015

### 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: Illinois, California, Texas  
 Certification(s)/Specialty: Orthopedic Surgery

### 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 42-year-old male who sustained an industrial injury on 4/27/15. The mechanism of injury was not documented. The 5/23/15 lumbar spine MRI revealed a diffuse disc bulge at L5/S1 with left paracentral/foraminal disc extrusion resulting in moderate narrowing of the left lateral recess with displacement of the descending left S1 nerve root, and severe left subarticular narrowing with likely impingement of the exiting left L5 nerve root. At L4/5, there was mild narrowing of both lateral recesses with moderate bilateral subarticular and mild bilateral neuroforaminal narrowing. There was slight narrowing of the normal lumbar lordosis with 4 mm retrolisthesis of L5 on S1. The 6/29/15 electrodiagnostic study evidence acute left L5 and S1 radiculopathy. The 9/3/15 utilization review cited grade 7/10 intermittent low back pain radiating down the left leg to the foot. Physical exam documented lumbosacral tenderness and spasms, tenderness over the thoracolumbar junction, L5/S1 facet joints and sciatic notches, right greater than left. There was decreased sensation along the left L5 and S1 dermatomes, 3/6 left tibialis anterior weakness, and 0/5 left extensor hallucis longus strength. There was foot drop on the left. Conservative treatment had included acupuncture, steroid medication, physical therapy, and epidural injection without sustained benefit. Authorization was requested for L4/5 and L5/S1 microdiscectomy, left sided hemilaminectomy, foraminotomy and decompression with associated surgical requests for inpatient stay, post-operative cryotherapy 2x6, and post-operative physical therapy 2x6. The 10/14/15 utilization review certified the request for L4/5 and L5/S1 microdiscectomy, left sided hemilaminectomy, foraminotomy and decompression with a 1-day inpatient stay and 12 visits of post-operative physical therapy. The request for post-operative cryotherapy 2x6 was non-certified as there was no evidence that a more complicated cold therapy unit would provide any additional benefit over conventional ice packs.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Post-operative cryotherapy 2x6:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004.  
Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back.

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Physical Methods. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), Occupational Medical Practice Guidelines, Chapter 12 Low Back Disorders (Revised 2007), Hot and cold therapies, page(s) 160-161.

**Decision rationale:** The California MTUS are silent regarding cold therapy devices, but recommend at home applications of cold packs. The ACOEM Revised Low Back Disorder Guidelines state that the routine use of high-tech devices for cold therapy is not recommended in the treatment of lower back pain. Guidelines support the use of cold packs for patients with low back complaints. Guideline criteria have not been met. There is no compelling reason submitted to support the medical necessity of a cold therapy unit in the absence of guideline support and over standard cold packs. Therefore, this request is not medically necessary.