

<b>Case Number:</b>	CM15-0020264		
<b>Date Assigned:</b>	02/09/2015	<b>Date of Injury:</b>	03/30/2011
<b>Decision Date:</b>	04/06/2015	<b>UR Denial Date:</b>	01/26/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/03/2015

### 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

### 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 48-year-old female who reported an injury on 03/30/2011. The mechanism of injury was a motor vehicle accident. Past treatment was noted to include physical therapy and cervical fusion at C4-5. At her followup visit on 12/17/2014, the injured worker reported moderate neck pain with radiating symptoms into her left arm. The physical examination revealed tenderness in the left paracervical area, decreased range of motion with pain, positive Spurling's maneuver, weakness in the left hand and triceps, and diminished sensation through the left thumb and index finger. The treatment plan included hardware removal at C4-5, as well as decompression at C5-6 and insertion of a new plate at that segment. A request was received for a postoperative hot/cold therapy unit with wrap for purchase. However, a specific rationale for this request was not provided.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Post Op Hot/Cold Therapy Unit with Wrap (purchase): 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), Low Back- Lumbar & Thoracic (Acute & Chronic) (11/21/14).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee & leg, Continuous-flow cryotherapy.

**Decision rationale:** According to the 01/22/2015 peer review, the injured worker had been given certification for the recommended cervical spine surgery. According to the Official Disability Guidelines, continuous flow cryotherapy cold units are recommended for up to 7 days postoperative use. The clinical information submitted for review indicated that he injured worker has been approved for surgery. Therefore, postoperative use of a cold therapy unit would be supported. However, as the guidelines only recommend use of cold therapy units for up to 7 days, the purchase of a unit as requested is not supported. Therefore, the request is not medically necessary.