

|                       |              |                              |            |
|-----------------------|--------------|------------------------------|------------|
| <b>Case Number:</b>   | CM15-0020537 |                              |            |
| <b>Date Assigned:</b> | 02/10/2015   | <b>Date of Injury:</b>       | 08/11/2014 |
| <b>Decision Date:</b> | 03/31/2015   | <b>UR Denial Date:</b>       | 01/26/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 02/04/2015 |

### 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: Minnesota, Florida  
 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:

The injured worker is a 59 year old male who sustained an industrial injury on 08/11/2014. Current diagnoses include sprain/strain-lumbar region, potential cauda equina syndrome and severe spinal stenosis. Previous treatments included medication management. Report dated 01/05/2015 noted that the injured worker presented with complaints that included pain in the low back and left leg. Physical examination was positive for abnormal findings. Surgery for the lower back was certified. Utilization review performed on 01/26/2015 non-certified a prescription for cold compression unit, based on the guidelines recommendations. The reviewer referenced the Official disability Guidelines in making this decision.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Post op Cold compression unit:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Section: Lower Back, Topic: cold packs

**Decision rationale:** ODG guidelines indicate cold packs are recommended as an option for low back pain. Continuous flow cryotherapy is recommended as an option for knee and shoulder surgery for 7 days after surgery. It reduces pain, swelling, inflammation, and need for narcotics. However, there is no such recommendation for low back surgery. Utilization review recommended a 7 day rental of cold compression for the lower back. The request as stated does not specify purchase or rental and does not specify the duration of rental. As such, the medical necessity of the request is not established.