

<b>Case Number:</b>	CM15-0023178		
<b>Date Assigned:</b>	02/12/2015	<b>Date of Injury:</b>	04/13/2014
<b>Decision Date:</b>	04/07/2015	<b>UR Denial Date:</b>	01/20/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/06/2015

### 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, Arizona

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 57-year-old male who reported an injury on 04/13/2014. The mechanism of injury occurred while working as a bus driver. His diagnoses include lumbar disc displacement. His past treatments include chiropractic care, duty modification, physical therapy, medications, and injections. On 11/06/2014, the injured worker complained of increasing low back pain with progressive neurologic deficits. The injured worker also complained of radicular pain, with noted greater weakness in the bilateral legs. The injured worker indicated he had an epidural steroid injection on 10/04/2014, without lasting relief of symptoms, and has failed other conservative measures, including duty modification and physical therapy. The physical examination of the lumbar spine revealed tenderness with spasms over the paravertebral muscles, across iliac crest into the lumbosacral spine, and a positive nerve root test. The lumbar range of motion was indicated to be guarded and restricted with flexion and extension. However, there was no clinical evidence of instability on examination. The injured worker's sensation, strength, and reflexes were indicated to be decreased. His relevant medications were not provided for review. The treatment plan included an ice unit for purchase. The request was for postoperative treatment. A Request for Authorization was not submitted.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Associated Surgical Service: Ice Unit for purchase: Upheld**

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

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

**Decision rationale:** The request for an ice unit for purchase is not medically necessary. According to the Official Disability Guidelines, continuous flow cryotherapy units are recommended postoperatively for use up to 7 days, including inhome use. The continuous flow cryotherapy units are also indicated for surgical procedures in the shoulder and knee. However, there was a lack of documentation of a clear rationale to indicate the medical necessity for an ice unit purchase over a rental. There was a lack of documentation to specify medical necessity for postoperative use for the lumbar spine. Based on the above, the request is not supported by the evidence based guidelines. As such, the request is not medically necessary.