

<b>Case Number:</b>	CM15-0058107		
<b>Date Assigned:</b>	04/02/2015	<b>Date of Injury:</b>	08/30/2012
<b>Decision Date:</b>	05/13/2015	<b>UR Denial Date:</b>	03/17/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/26/2015

### 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 46 year old male, who sustained an industrial injury on 05/29/2012. On provider visit dated 02/24/2015 the injured worker has reported continued low back pain that radiates to his legs with weakness and tingling noted. On examination of the lumbar spine there was noted tenderness to palpation noted over the paravertebral region and spinous processes bilaterally. Manual muscle testing of the lumbosacral spine revealed 4/5 strength with flexion, extension and bilateral lateral bend. Range of motion was restricted due to pain. He was noted to be scheduled for a lumbar spine fusion surgery. The diagnoses have included lumbar degenerative disc disease, lumbar disc displacement, lumbar neuritis and lumbar spinal stenosis. Treatment to date has included MRI's, CT scans, physical therapy, chiropractic care, acupuncture, bracing, anti-inflammatory medication and epidural injections. The provider requested cold therapy unit, post operatively for lumbar spine, duration and frequency unknown.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Cold therapy unit, post operatively for lumbar spine, duration and frequency unknown:**  
 Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 304-306.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG: Section: Low back, Topic: cold packs; Section: knee: Topic: continuous flow cryotherapy.

**Decision rationale:** ODG guidelines recommend cold packs; however, a continuous flow cryotherapy unit is not recommended for the lower back. The guidelines do recommend continuous flow cryotherapy as an option for 7 days after shoulder and knee surgery. The request as stated does not specify if it is a purchase or rental and also does not specify the duration of the rental. As such, the medical necessity of the requested cold therapy unit cannot be determined.