

<b>Case Number:</b>	CM14-0139600		
<b>Date Assigned:</b>	09/05/2014	<b>Date of Injury:</b>	05/16/2013
<b>Decision Date:</b>	10/09/2014	<b>UR Denial Date:</b>	08/13/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/28/2014

### 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. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 female who reported a date of injury of 05/16/2013. The mechanism of injury was reported as a fall. The injured worker had diagnoses of chronic bilateral L3 radiculopathy, lumbarization of S1, 3mm disc protrusion at L5-S1, post-concussion headaches and musculoligamentous sprain/strain of the cervical and lumbar spine. Prior treatments included physical therapy and acupuncture. The injured worker had an MRI on 03/13/2014, EMG/NCV study of the upper extremities on 07/10/2014, an EMG/NCV study of the lower extremities on 03/18/2014, and an x-ray of the lumbosacral spine on 05/15/2014. Surgeries were not indicated within the medical records received. The injured worker had complaints of constant pain and discomfort of the lumbar spine with associated numbness radiating down the right leg to the foot, she rated the pain at 8/10. The clinical note dated 06/10/2014, noted the injured worker had tenderness to palpation and spasms over the lumbar spine. Range of motion of the lumbar spine was restricted with 40 degrees of flexion and 20 degrees of extension and a positive straight leg raise. Medications included Ultram and Flexeril. The treatment plan included Ultram, Flexeril, the physician's recommendation for acupuncture treatments, X-Force TENS unit, a Solar Care infrared heating pad and a pain management consult. The rationale and request for authorization form were not provided within the medical records.

### IMR ISSUES, DECISIONS AND RATIONALES

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

█ **Cold Therapy Recovery System with wrap, 21 day rental:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) - Treatment for Workers' Compensation (TWC), Online Edition, Chapter: Neck and Upper Back, Cold Pack and Chapter: Low Back - Lumbar & Thoracic, Cryotherapy.

**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 a [REDACTED] Cold Therapy Recovery System with wrap, 21 day rental is not medically necessary. The injured worker had complaints of constant pain and discomfort of the lumbar spine with associated numbness radiating down the right leg to the foot, she rated the pain at 8/10. The Official Disability Guidelines (ODG) recommend continuous-flow cryotherapy as an option after shoulder surgery, but not for nonsurgical treatment. Continuous-flow cryotherapy has been proven to decrease pain, inflammation, swelling and narcotic usage, however, the effect on acute injuries such as muscle strains and contusions has not been fully evaluated. Postoperative use generally may be up to 7 days, including home use. There is a lack of documentation indicating the injured worker underwent surgical intervention or is scheduled to undergo surgery which would require the post-operative use of continuous flow cryotherapy in the near future. The requesting physician's rationale for the request is not indicated within the provided documentation. The request for a 21 day rental would exceed the guideline recommendation of 7 days of post-operative use. The submitted request does not indicate the site at which the unit is to be used. As such, the request is not medically necessary.