

<b>Case Number:</b>	CM14-0140527		
<b>Date Assigned:</b>	09/10/2014	<b>Date of Injury:</b>	03/29/2002
<b>Decision Date:</b>	10/14/2014	<b>UR Denial Date:</b>	08/21/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/29/2014

### 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 Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in Florida. 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 51 year old female who reported an injury on 03/29/2002. The mechanism of injury was lifting boxes of soda. Her diagnoses included post laminectomy syndrome of the lumbar spine and myalgia of the lower back. The injured worker's treatments included a percutaneous peripheral nerve stimulator, medications, physical therapy, transcutaneous electrical nerve stimulation, lumbar surgeries to include fusion, home exercise, and injections. Her diagnostic exams included a nerve conduction study/electromyography on 07/16/2014, which was negative for abnormalities. On 07/10/2014, the injured worker complained of bilateral low back pain and lower extremity pain. She rated this pain at 8/10. The injured worker also indicated that she was able to successfully reduce her medications since the last visit, but it caused an increase in her pain level. The physical exam revealed that her clinical findings were unchanged since her previous visit. Her medications included Opana ER and Subsys. The treatment plan encompassed the replacement of her cold therapy unit, which provided great relief during use. Also, a continuation of reduction of medications would be continued, along with the request for additional nerve stimulation sessions. The requested treatment was for 1 cold therapy unit replacement. The rationale for the request was that the cold therapy unit provided great low back pain relief. The Request for Authorization form was not submitted.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**1 Cold Therapy Unit Replacement: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Treatment Index, 11th Edition (web), 20134 Low back, Lumbar & Thoracic (Acute & Chronic), Cold/heat packs

**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:** The request for 1 cold therapy unit replacement is not medically necessary. The Official Disability Guidelines recommend continuous-flow cryotherapy, but not for non-surgical treatment. Postoperative use generally may be up to 7 days, including home use. Mechanical circulating units with pumps have not been proven to be more effective than passive hot and cold therapy. Based on the clinical notes, the injured worker had a lumbar fusion surgery prior to 04/03/2014. The clinical notes do not clearly identify the date of the surgery in order to make a sound clinical judgment to determine medical necessity; however, the injured worker has exceeded 7 days since surgery. Therefore, despite documentation of the injured worker reports relief of symptoms with the cold therapy unit, it is not a long term treatment option. The guidelines state that continuous cold therapy is recommended after surgery, but not for non-surgical treatment. The request for a replacement unit suggests that the injured worker has procured the equipment for longer than the recommend 7 days post-surgery and is there for not supported. Therefore, the request for 1 cold therapy unit replacement is not medically necessary.