

Case Number:	CM14-0161605		
Date Assigned:	10/07/2014	Date of Injury:	05/03/2003
Decision Date:	10/31/2014	UR Denial Date:	09/02/2014
Priority:	Standard	Application Received:	10/01/2014

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 Preventive Medicine 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:

According to the records made available for review, this is a 46-year-old male with a 5/3/03 date of injury. At the time (7/24/14) of request for authorization for Motorized cold therapy unit, there is documentation of subjective (chronic left sided lower back pain) and objective (tenderness to palpitation over the facet area of L4-L5 and L5-S1 on the left side, positive Patrick test, and positive facet loading test) findings, current diagnoses (lumbar sprain, cervical intervertebral disc disorder with myelopathy, and lumbosacral neuritis/radiculitis), and treatment to date (S1 medial block injection).

IMR ISSUES, DECISIONS AND RATIONALES

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

Motorized cold therapy 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 (ODG), Treatment Index, 12th Edition (web), 2014: Knee Chapter, Continuous Flow Cryotherapy

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Cold/heat packs Other Medical Treatment Guideline or Medical Evidence: PMID: 18214217 PubMed - indexed for MEDLINE

Decision rationale: MTUS reference to ACOEM guidelines identifies at-home applications of local heat or cold to the low back as an optional clinical measure for evaluation and management of low back complaints. ODG identifies that there is minimal evidence supporting the use of cold therapy. Medical Treatment Guideline identifies that exact recommendations on application, for cold therapy utilization, on time and temperature cannot be given. Therefore, based on guidelines and a review of the evidence, the request for Motorized cold therapy unit is not medically necessary.