

<b>Case Number:</b>	CM14-0210779		
<b>Date Assigned:</b>	12/23/2014	<b>Date of Injury:</b>	02/12/2014
<b>Decision Date:</b>	02/19/2015	<b>UR Denial Date:</b>	11/26/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/16/2014

### 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. 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: Indiana

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This employee is a 42 year old male with date of injury of 2/12/2014. A review of the medical records indicate that the patient is undergoing treatment for lumbar strain and sprain. Subjective complaints include continued pain in the lower back with radiation down bilateral lower extremities. Objective findings include limited range of motion of the lumbar spine with tenderness to palpation of the paravertebrals and positive Fabere's, Sacroiliac Thrust, and Yeoman's tests. Treatment has included bilateral medial branch facet joint rhizotomy and neurolysis. The utilization review dated 11/26/2014 non-certified a hot and cold unit post operatively for 30 days.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Hot and cold unit post operatively 30 days: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300,Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation ODG-TWC Low back procedure summary

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back

(Lumbar and Thoracic), Lumbar Support; Other; Medical Treatment Guideline or Medical Evidence: <http://www.deroyal.com/medicalproducts/orthopedics/product.aspx?id=pc-temptherapy-coldtherunit>.

**Decision rationale:** MTUS is silent on the use of cold therapy units. ODG for heat/cold packs states "Recommended as an option for acute pain. At-home local applications of cold packs in first few days of acute complaint; thereafter, applications of heat packs or cold packs. (Bigos, 1999) (Airaksinen, 2003) (Bleakley, 2004) (Hubbard, 2004) Continuous low-level heat wrap therapy is superior to both acetaminophen and ibuprofen for treating low back pain. (Nadler 2003) The evidence for the application of cold treatment to low-back pain is more limited than heat therapy, with only three poor quality studies located that support its use, but studies confirm that it may be a low risk low cost option. (French-Cochrane, 2006) There is minimal evidence supporting the use of cold therapy, but heat therapy has been found to be helpful for pain reduction and return to normal function. (Kinkade, 2007)". The use of devices that continually circulate a cooled solution via a refrigeration machine have not been shown to provide a significant benefit over ice packs. As such the request for hot and cold therapy unit is not medically necessary.