MAXIMUS Federal Services

Case Number:	CM14-0216761		
Date Assigned:	01/06/2015	Date of Injury:	01/22/2014
Decision Date:	02/28/2015	UR Denial Date:	11/25/2014
Priority:	Standard	Application Received:	12/26/2014

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: California
Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 51 year old male sustained a work related injury on 1/22/2014. The current diagnoses are chronic back pain with degenerative disc disease at the level of L2-L3, L3-L4, L4-L5, and L5-S1, lumbar spine spondylosis, right knee pain, and status post right knee arthroscopy (8/19/2014). According to the progress report dated 11/6/2014, the injured workers chief complaints were low back pain with radiating pain into the right lower extremity associated with tingling and numbness. Additionally, he reported right knee pain. The physical examination revealed tenderness over the lumbar paraspinal muscles and midline. Deep tendon and Achilles reflexes on the right side are diminished. Motor strength is decreased on right quadriceps, tibialis anterior, extensor halluces and gastrocnemius 4/5. There was decreased sensation to light touch on right L3, L4, L5, and S1 direction. Straight leg raise test was positive on the right. Axial loading is positive. Range of motion of the lumbar spine was decreased. Spasm was noted with range of motion. The medication list was not specified in the progress reports provided. According to the Utilization Review, the injured worker was previously treated with medications, physical therapy, intra-articular injections and epidurals. On this date, the treating physician prescribed motorized cold therapy unit for purchase, which is now under review. The motorized cold therapy unit was prescribed specifically for post injection. In addition to motorized cold therapy unit, the treatment plan included lumbar epidural steroid injection, Norco, Gabapentin, and compound analgesic cream. When motorized cold therapy unit for purchase was prescribed work status was not described.On 11/25/2014, Utilization Review had non-certified a prescription for motorized cold therapy unit for purchase. The motorized cold

therapy unit for purchase was non-certified based on no evidence that his treatment modality is any more effective than the local application of an ice pack. The Official Disability Guidelines were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Motorized cold therapy unit for purchase: 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), Knee and Leg Chapter, Cold Therapy Unit, Low Back Chapter, Cold Therapy

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation low back chapter, cold and heat pack

Decision rationale: This patient presents with low back pain radiating to the right lower extremity and right knee pain. The treater is requesting a DME MOTORIZED COLD THERAPY UNIT FOR PURCHASE ONLY, BODY PART LUMBAR SPINE. The patient's work status is modified duty. The MTUS and ACOEM Guidelines do not address this request. However, ODG Guidelines under the low back chapter on cold and heat pack states that it recommended at-home local applications of cold packs in the first few days of acute complaints, thereafter, application of heat packs. ODG further states that mechanical circulating units with pumps have not been proven to more effective than passive hot/cold therapy.The records do not show any previous request for motorized cold therapy unit. The treater is requesting this motorized cold therapy unit following a lumbar epidural steroid injection. ODG Guidelines do not support the use of mechanical circulating units. The request IS NOT medically necessary.