Case Number:	CM14-0098792		
Date Assigned:	07/28/2014	Date of Injury:	09/28/2012
Decision Date:	10/13/2015	UR Denial Date:	06/06/2014
Priority:	Standard	Application Received:	06/27/2014

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, Indiana, New York
Certification(s)/Specialty: Internal 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 is a 52-year-old female worker who was injured on 9-28-12. The medical records reviewed indicated the injured worker (IW) was treated for lumbar radiculopathy. The progress notes (6-25-13) indicated the IW was scheduled for spinal surgery on 6-27-13. On physical examination (6-25-13) the IW had tenderness over the paraspinal musculature. Range of motion (ROM) was documented in degrees as 60, flexion; 25, extension; and 25, left and right lateral flexion. Sensation was diminished over the bilateral S1 dermatomes. Achilles and patellar reflexes were 2+ and there was no Achilles clonus. Straight leg raise was negative. The treating provider requested the cold therapy unit for use postoperatively. A postoperative exam (6-28-13) revealed the surgical wound was without erythema and exudate and there was no swelling beyond postoperative surgical changes. The postoperative evaluation (9-20-13) noted the IW had back pain rated 8 out of 10. Lumbar ROM was 40 degrees flexion, 10 degrees extension and 10 degrees lateral bending, left and right. She was to start physical therapy as soon as possible. A Request for Authorization dated 5-22-14 asked for retrospective review for a motorized cold therapy unit. The Utilization Review on 6-6-14 non-certified the request for a motorized cold therapy unit, as home applications of ice or cold packs would suffice for edema control.

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 ACOEM-California plus Guidelines, Ankle and Foot Complaints, Clinical Measures, Hot and Cold Therapies-Cryotherapies.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain section, Continuous flow cryotherapy.

Decision rationale: Pursuant to the Official Disability Guidelines, motorized cold therapy unit is not medically necessary. Continuous flow cryotherapy is recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use (maybe) for up to 7 days, including home use; in the postoperative setting, continuous flow cryotherapy units have been proven to decrease pain, inflammation, swelling and narcotic use; however, the effect on more frequently treated acute injuries has not been fully evaluated. Continuous low-level heat wrap therapy is superior to both acetaminophen and ibuprofen for treating low back pain. Evidence for application of cold treatment to low back pain is more limited than the therapy. 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 activities. In this case, the injured worker's working diagnosis is lumbar radiculopathy. Date of injury is September 28, 2012. Request for authorization is June 27, 2013. According to a June 25, 2013 progress note, the worker is scheduled for L5-S1 decompression and fusion. There is no clinical indication or rationale for a motorized therapy unit. 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 activities. There is no timeframe documented for the motorized cold therapy unit. Based on clinical information in the medical record, peer-reviewed evidence-based guidelines and a specific request for duration of use, motorized cold therapy unit is not medically necessary.