

<b>Case Number:</b>	CM15-0012127		
<b>Date Assigned:</b>	01/29/2015	<b>Date of Injury:</b>	09/13/2013
<b>Decision Date:</b>	03/25/2015	<b>UR Denial Date:</b>	12/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/21/2015

### 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, Hawaii

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 64 year old man sustained an industrial injury on 9/13/2013. The mechanism of injury was not detailed. Current diagnoses include neck pain with radicular symptoms to left upper extremity with C4-C5 and C5-C6 disc protrusion with neuroforaminal stenosis, paracervical and bilateral upper trapezius muscle spasm, and low back pain with radicular symptoms to the left lower extremity. Treatment has included oral medications, trigger point injections, and physical therapy. Physician notes dated 10/6/2014 show continued complaints of low back pain with radiation to the left lower extremity, neck pain with radiation to the left upper extremity, headache, and tightness in her bilateral upper shoulder areas. The treatment plan includes trigger point injections to the bilateral upper trapezius muscle, requesting authorization for cervical epidural steroid injection, motorized cold therapy unit for purchase and use post-injection, requesting authorization for Tizanidine for muscle relaxation, discontinue Baclofen, requesting authorization for compounded analgesic topical cream, continue Tramadol, and return in six weeks for follow up. On 12/24/2014, Utilization Review evaluated a prescription for cold therapy unit, that were submitted on 1/15/2015. The UR physician noted that continuous flow cryotherapy units are not indicated following non-surgical interventions or for the neck. The MTUS, ACOEM Guidelines (or ODG) was cited. The request was denied and subsequently appealed to Independent Medical Review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Cold Therapy unit purchase:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines: Neck & Upper Back; Continuous flow cryotherapy units

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Continuous cold therapy

**Decision rationale:** The patient presents with low back pain with radiation to the left lower extremity, neck pain with radiation to the left upper extremity, headache and tightness in her bilateral upper shoulder areas. The current request is for Cold Therapy unit purchase. The treating physician on 10/6/14 (10A) states "I would like to order the following for the patient to be utilized post injection: Motorized Cold Therapy Unit for purchase only." The treating physician's treatment plan calls for the patient to use the Cold Therapy unit following trigger point injection to the bilateral upper trapezius and following Epidural Steroid Injection (ESI) at the level of C4-C5, C5-C6. Both the trigger point and ESI were deemed not medically necessary according to the clinical history provided. The MTUS and ACOEM guidelines do not discuss cold therapy units. Therefore, ODG Guidelines are referenced. The ODG have the following regarding continuous-flow cryotherapy: "Recommended as an option after surgery but not for nonsurgical treatment." In the clinical history provided there is no indication of recent or projected surgery. ODG does not recommend continuous-flow cryotherapy for nonsurgical treatment. Therefore, the requested cold therapy unit has not established medical necessity per ODG, and recommendation is for denial.