

Case Number:	CM15-0013362		
Date Assigned:	02/02/2015	Date of Injury:	09/21/2013
Decision Date:	03/27/2015	UR Denial Date:	12/30/2014
Priority:	Standard	Application Received:	01/23/2015

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

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:

The injured worker (IW) is a 45 year old male who sustained an industrial injury on 09/21/2013. He has reported low back pain. Diagnoses include lumbar sprain and strain, lumbar spine spondylosis at the level of L4-5 and S1, and right lumbar radiculopathy in the direction of L4, L5, and S1. Treatments to date include an epidural steroid injections, of which the most recent one was received on 10/06/2014 with reported significant improvement in his low back pain and radiating symptoms to the lower extremities. He has had physical therapy and treatment in a pain clinic until his discharge from that clinic on 12/08/2014. In a progress note dated 12/08/2014 the treating provider reports the IW has subjective complaints of low back pain but reports significant improvement in his back pain and is working again. Pain medications are taken only as needed. Objective findings were: heel walk and toe walk normal, deep tendon reflexes in patella and Achilles are normal, motor exam in bilateral lower extremities is 5/5. And sensation examination of lower extremities is intact. On 12/30/2014 Utilization Review non-certified a request for 1 post-injection motorized cold therapy unit, noting the guidelines do not support the use of a continuous flow cryotherapy unit for treatment of post-injection or post-operative lumbar procedures. The ACOEM Guidelines, Chapter 12 Low Back Complaints were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 post-injection motorized cold therapy unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines low back chapter has the following regarding continuous-flow cryotherapy

Decision rationale: This patient presents with chronic low back pain and has undergone a lumbar epidural injection on 10/06/2014. The patient reports significant improvement following the epidural injection. The current request is for one post-injection motorized cold therapy unit. According to progress report dated 11/03/2014, the treating physician recommended that the patient utilize a motorized cold therapy unit and a request was made for "purchase only." The ODG Guidelines under the low back chapter has the following regarding continuous-flow cryotherapy; "recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be 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 effectiveness on more frequently treated acute injuries has not been fully evaluated." In this case, the treating physician is requesting the use of continuous-flow cryotherapy following an injection. ODG does not recommend continuous-flow cryotherapy for nonsurgical treatment. Furthermore, this request is for purchase of a unit without specifying duration and ODG recommends 7 days of use following surgery. The request is not medically necessary.