

<b>Case Number:</b>	CM15-0016339		
<b>Date Assigned:</b>	02/04/2015	<b>Date of Injury:</b>	01/28/2011
<b>Decision Date:</b>	03/24/2015	<b>UR Denial Date:</b>	01/21/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/28/2015

### 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: New York

Certification(s)/Specialty: Internal Medicine, Pulmonary Disease

### 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 is a 50 year old female, who sustained an industrial injury on 1/28/2011. She is status post L5-S1 laminectomy, bilateral medial facetectomy and foraminotomies, posterolateral fusion and posterior instrumentation on 6/30/2014. The diagnoses have included status post lumbar surgery. Treatment to date has included magnetic resonance imaging (MRI), physical therapy, medications and surgical intervention. Currently, the IW complains of constant moderate to severe lower back pain. She is wearing an LSO brace. The pain is described as constant dull, aching pain with frequent sharp, stabbing pain. There is stiffness and tightness. Objective examination revealed a nontender lumbar spine to direct palpation and no muscle spasm present. Range of motion is 30% flexion, 0% extension, 20% lateral bending on the right and 30% lateral bending on the left. Straight leg raise test is negative bilaterally. On 1/21/2015 Utilization Review non-certified a request for motorized cold therapy unit purchase for the lumbar spine, noting that the current evidence does not support the routine use of cryotherapy. The ODG was cited. On 1/28/2015, the injured worker submitted an application for IMR for review of chair back brace purchase for the lumbar spine (approved) motorized cold therapy unit purchase for the lumbar spine, shower chair purchase for the lumbar spine (approved), 3 in 1 commode purchase for the lumbar spine (approved) and front wheel walker purchase for the lumbar spine (approved).

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Purchase of motorized cold therapy unit for the lumbar spine, provided on date of service: 06/30/14:** 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), Low Back, Cold/heat packs

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Back, Cold Therapy

**Decision rationale:** ACOEM Chapter 12, Low Back complaints does not mention a motorized cold therapy machine as a treatment. ODG notes that there is minimal evidence to support a cold therapy unit. Although not a standard of care and there is no evidence that the use of cold therapy post operatively improves the long term outcome of orthopedic surgery - it might make the most sense of using this modality for an acute injury, not when the injury was on 01/28/2011 and the surgery was on 06/30/2014. The requested motorized cold therapy unit is not medically necessary for this patient at this point in time.