

<b>Case Number:</b>	CM15-0043383		
<b>Date Assigned:</b>	03/13/2015	<b>Date of Injury:</b>	01/14/2013
<b>Decision Date:</b>	04/22/2015	<b>UR Denial Date:</b>	02/09/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/06/2015

### 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, District of Columbia, Maryland  
Certification(s)/Specialty: Anesthesiology, Pain Management

### 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 male who sustained an industrial injury on January 14, 2013. He has reported pain to the low back and has been diagnosed with low back pain with radiating symptoms to the right lower extremity, right SI joint arthropathy, and rule out lumbar spondylosis. Treatment has included modified work restrictions, medications, and physical therapy. Currently the injured worker reports pain as constant and rates it at 8-9/10. The pain was noted as severe in the right lumbosacral area radiating to his right lower extremity. The treatment request included 1 purchase of motorized cold therapy unit.

### 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:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee Chapter.

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

**Decision rationale:** The most recent progress note is dated January 15, 2015 and includes a request for a motorized cold therapy unit for purchase to be used post injection. Although it is not stated for which objection specifically, it is assumed that this is for a right SI joint steroid injection that was requested previously. Not only has this right SI joint steroid injection not been approved, but also the official disability guidelines recommend the use of such a unit in a postoperative setting, not for injections. Even then, use is only recommended for seven days of the postoperative period, so purchase would not be necessary. For these multiple reasons, this request for the purchase of a motorized cold therapy unit is not medically necessary.