

|                       |              |                              |            |
|-----------------------|--------------|------------------------------|------------|
| <b>Case Number:</b>   | CM14-0155881 |                              |            |
| <b>Date Assigned:</b> | 09/25/2014   | <b>Date of Injury:</b>       | 07/27/2011 |
| <b>Decision Date:</b> | 11/04/2014   | <b>UR Denial Date:</b>       | 09/10/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 09/23/2014 |

### 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. The expert reviewer is Board Certified in Internal Medicine and is licensed to practice in New York. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 claimant is a 35 year old male who sustained an industrial injury on 07/27/2011. The mechanism of injury was he was struck by a falling pipe while wearing a hard hat and sustained a closed head injury, left scapula fracture, left shoulder fracture, 5 left-sided rib fractures and 4 vertebrae fractures. Medical records were reviewed. He continues to complain of neck, left shoulder and low back pain with associated bilateral leg weakness. The only documentation of objective physical findings is "complains of headaches, dizziness and difficulty sleeping"- all subjective complaints. Treatment has included medications, chiropractic care and acupuncture. The treating provider has requested purchase of a Hot/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 a Hot/Cold Therapy Unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: CMS Medicare/Blue Cross of California Medical Policy Durable Medical Equipment.

**Decision rationale:** The guidelines from CMS Medicare/Blue Cross of California Medical Durable Medical Equipment note that durable medical equipment is defined as an item which

provides therapeutic benefits or enables the member to perform certain tasks that he or she is unable to undertake otherwise due to certain medical conditions or illnesses. There is no specific documentation provided indicating the medical necessity for the requested hot/cold unit. There has been no recent surgical procedure and the use of standard hot and cold packs should be adequate for treatment. Medical necessity for the requested item has not been established. The requested item is not medically necessary.