

# INDEPENDENT REVIEWERS OF TEXAS, INC.

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Notice of Independent Review Decision

**[Date notice sent to all parties]:**

**12/4/2014 and 1/05/2015**

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: 7 day  
cryotherapy unit 09/17/2014 – 11/16/2014**

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR  
OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:**

Board Certified Neurological Surgery

**REVIEW OUTCOME:**

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a male who was taken to surgery on 09/17/14, for a preoperative diagnosis of lumbar radiculopathy and a herniated disc at L4-5. Procedure performed was a lumbar micro discectomy, laminectomy, foraminotomy, and partial facetectomy at L4-5 on the right.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL  
BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:**

On 08/28/14, an order was submitted for durable medical equipment including hot and cold therapy unit. On 09/15/14, a utilization review determination stated the

requested service for 7 day rental of a continuous cryotherapy unit between 09/10/14 and 11/09/14 was non-certified. It was noted that while cold therapy is considered essential in addressing postoperative inflammation and pain, there is currently limited evidence to support the superiority of a motorized unit over the conventional heat or cold packs beyond their obvious convenience. Medical necessity was not established. Official Disability Guidelines Low Back Chapter, addressed heat therapy and states cold and heat packs may be recommended as an option for acute pain and at home local applications of cold packs in the first few days of acute complaints may be recommended. They indicate the evidence for the application for treatment to low back pain is more limited to heat therapy with only 3 poor quality studies located to support its use but studies confirm that it may be a low risk low cost option. Guidelines indicate there is minimal evidence supporting the use of cold therapy but heat therapy has been found to be helpful for pain reduction and return to normal function. The submitted records do not indicate the patient had the inability to apply local applications of cold to his back following his surgery. Recommendation is for non-certification of this request and upholding the previous determinations.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

**MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

**ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**

**Cold/heat packs**

Recommended as an option for acute pain. At-home local applications of cold packs in first few days of acute complaint; thereafter, applications of heat packs or cold packs. (Bigos, 1999) (Airaksinen, 2003) (Bleakley, 2004) (Hubbard, 2004) Continuous low-level heat wrap therapy is superior to both acetaminophen and ibuprofen for treating low back pain. (Nadler 2003) The evidence for the application of cold treatment to low-back pain is more limited than heat therapy, with only three poor quality studies located that support its use, but studies confirm that it may be a low risk low cost option. (French-Cochrane, 2006) There is minimal evidence supporting the use of cold therapy, but heat therapy has been found to be helpful for pain reduction and return to normal function. (Kinkade, 2007) See also Heat therapy; Biofreeze® cryotherapy gel.

**Cryotherapy**

**See Cold/heat packs.**