

Case Number:	CM13-0026160		
Date Assigned:	11/22/2013	Date of Injury:	08/26/2004
Decision Date:	02/27/2014	UR Denial Date:	08/26/2013
Priority:	Standard	Application Received:	09/18/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Pain Management and Rehabilitation and has a subspecialty in Interventional Spine and is licensed to practice in California. 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 physician 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 patient is a 48 YO male with a date of injury of 08/26/2004. The listed diagnoses per [REDACTED] dated 08/13/2013 are 1. Lumbar radiculopathy 2. Failed back surgery syndrome 3. Lumbar Facet Arthropathy According to report dated 08/21/2013 by [REDACTED], patient presents with increased pain to the lower back, hips and bilateral legs, which he rates on pain scale 9/10. Examination of the lumbar spine revealed facet tenderness over the L3-L5 levels. Positive seated SLR bilaterally. Lumbar spine range of motion was reduced with lateral bending 15/15, flexion 30/30 and extension 10/10. Sensation was noted intact in all dermatomes except at the right L3 and left L3 through S1 dermatomes. Patient is status post caudal lumbar epidural steroid injection (July, 2013). Treater requests a spinal cord stimulator and cold therapy unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tech Fee A9901 Cold therapy unit E0218 Quantity 1: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: This patient presents with increased pain in lower back, hips and bilateral legs. Treater is requesting a cold/hot therapy unit "that provides continuous circulation and pressure." The MTUS and ACOEM guidelines do not discuss Cold Therapy units specifically, therefore ODG guidelines are referenced. ODG guidelines 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 usage; however, the effect on more frequently treated acute injuries (eg, muscle strains and contusions) has not been fully evaluated." The patient is status post lumbar fusion 02/15/2005. This patient is out of post-operative recovery time-frame and therefore, the request for continuous flow cold therapy is for the patient's chronic pain. ODG guidelines do not support this type of device other than for post-operative recovery. The request is not medically necessary and recommendation is for denial.