

<b>Case Number:</b>	CM13-0036451		
<b>Date Assigned:</b>	12/13/2013	<b>Date of Injury:</b>	07/17/2009
<b>Decision Date:</b>	02/13/2014	<b>UR Denial Date:</b>	10/01/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/21/2013

### 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 Orthopedic Surgery, has a subspecialty in Spine Surgery 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 56-year-old female who reported an injury on July 17, 2009. The mechanism of injury was not provided within the medical records, nor was the initial course of therapy. The patient initially complained of pain to her neck, left shoulder, bilateral wrists and hands, spine, low back, and bilateral knees. She received physical therapy with little relief. She received MRIs to her bilateral wrists and right knee. She underwent right wrist surgery in 2011 and continued to have ongoing mid and low back pain. She received acupuncture to her low back with benefit and was sent for an EMG/NCS, but did not complete the test due to increased pain. She underwent surgery to her left knee with postoperative physical therapy. She continued to have ongoing pain in the knee and injured it once again. Therefore, another left knee surgery was performed in 2012. It also stated that she received chiropractic treatment that caused a severe increase in pain with additional numbness and tingling in her legs, feet, and toes. The patient received an MRI of the lumbar spine on May 24, 2013 that revealed abnormalities. The patient continues to be symptomatic with low back pain, left shoulder pain, and neck pain. An MRI of the cervical spine performed on September 03, 2013 which revealed mild canal stenosis and bilateral neural foraminal narrowing at C3-4, grade 1 retrolisthesis and severe canal stenosis at C4-5 with right neural foraminal narrowing; severe canal stenosis and moderate bilateral neural foraminal narrowing at C5-6; and severe canal stenosis with severe bilateral neural foraminal narrowing and a 5 mm central and right paracentral disc protrusion at C6-7. In the most recent clinical note dated September 25, 2013, the patient was referred for immediate cervical surgery to include anterior decompression and fusion at C4-5, C5-6, and C6-7 levels. It was also noted that she would need a posterior laminectomy and fusion at C6-7 due to the severe compression

## IMR ISSUES, DECISIONS AND RATIONALES

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

**cold therapy unit:** 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), Neck & Upper Back, Continuous Flow Cryotherapy

**Decision rationale:** The California MTUS/ACOEM Guidelines do not specifically address the use of a cold therapy unit; therefore, the Official Disability Guidelines were supplemented. The ODG does not recommend the use of continuous-flow cryotherapy in the treatment of the neck. As this device was intended to be used after neck surgery, the request does not meet guideline recommendations. As such, the request for a cold therapy unit is not medically necessary or appropriate.

**wheelchair:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Power mobility devices (PMDs).

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

**Decision rationale:** The California MTUS/ACOEM Guidelines did not specifically address the use of wheelchairs; therefore, the Official Disability Guidelines were supplemented. The ODG states that manual wheelchairs are recommended if the patient requires and will use them to move around in their residence. There was no documentation provided detailing the patient's need for a wheelchair inside her residence, and there is no indication that she would be able to self-propel. As such, the request for a wheelchair is not medically necessary or appropriate.