

Case Number:	CM13-0043529		
Date Assigned:	12/27/2013	Date of Injury:	11/27/2011
Decision Date:	02/28/2014	UR Denial Date:	10/08/2013
Priority:	Standard	Application Received:	10/23/2013

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 Physical Medicine & Rehabilitation 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 36 -year-old male who reported an injury on 11/27/2011 while performing normal job duties as a sanitation worker. The patient reportedly sustained injury to the low back, knees, and right thigh. The patient's treatment history included physical therapy, chiropractic care, acupuncture, medication usage and epidural steroid injection therapy. The patient's most recent clinical evaluation of the knee revealed normal motor strength with no pain or apprehension with patellar grind and a normal valgus stability at 2 mm and valgus stability at 2 mm with negative orthopedic testing. Evaluation of the lumbar spine revealed bilateral facet tenderness at the L4-L5 and L5-S1, restricted range of motion secondary the pain. The patient's diagnoses included right knee medial meniscus tear the posterior horn, bilateral lumbosacral radicular pain in the L5-S1 distribution, and a lumbar sprain/strain.

IMR ISSUES, DECISIONS AND RATIONALES

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

Dynamic contrast therapy system, rental: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305. Decision based on Non-MTUS Citation ODG), Lumbar Chapter and Knee and Leg Chapter and Shoulder chapter, Hot/cold packs and continuous flow cryotherapy.

Decision rationale: The Physician Reviewer's decision rationale: The requested dynamic contrast therapy system for rental is not medically necessary or appropriate. The clinical documentation submitted for review does indicate that the intent is to rent this equipment for approximately 14 days. American College of Occupational and Environmental Medicine and Official Disability Guidelines recommend the application of heat and cold packs be self-managed by the patient for lumbar pain relief. Official Disability Guidelines do not recommend the use of a cold therapy unit in the absence of surgical intervention. The clinical documentation submitted for review does provide evidence that the patient did receive an epidural steroid injection; however, this routine outpatient procedure would not support the need for a cold therapy unit. Additionally, there is no documentation that the patient has failed to respond to self-managed alternating cold and heat packs. As such, the requested dynamic contrast therapy system for rental is not medically necessary or appropriate.

Full leg wrap, purchase: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305. Decision based on Non-MTUS Citation Lumbar Chapter and Knee and Leg Chapter and Shoulder chapter, Hot/cold packs and continuous flow cryotherapy.

Decision rationale: The Physician Reviewer's decision rationale: Official Disability Guidelines do not recommend the use of requested durable medical equipment in the absence of surgical intervention. The clinical documentation does not support that the patient recently underwent surgical intervention. Therefore, the purchase of a full leg wrap would not be medically necessary or appropriate

Universal therapy wrap, purchase: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Lumbar Chapter and Knee and Leg Chapter and Shoulder chapter, Hot/cold packs and continuous flow cryotherapy.

Decision rationale: The Physician Reviewer's decision rationale: Official Disability Guidelines do not recommend the use of requested durable medical equipment in the absence of surgical intervention. The clinical documentation does not support that the patient recently underwent surgical intervention. Therefore, the purchase of a universal therapy wrap would not be medically necessary or appropriate.