

Case Number:	CM13-0065201		
Date Assigned:	01/03/2014	Date of Injury:	05/16/2008
Decision Date:	05/16/2014	UR Denial Date:	12/05/2013
Priority:	Standard	Application Received:	12/12/2013

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, Pulmonary Diseases 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 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 patient is a 43-year-old male who reported an injury on 05/16/2008 after he was hit by a car. The patient reportedly sustained injury to his bilateral upper extremities and lumbar spine. The patient's treatment history included physical therapy, surgical intervention, and medications. The patient's most recent clinical evaluation documented that the patient had limited lumbar range of motion secondary to pain and limited left shoulder range of motion secondary to pain with a positive impingement sign. The patient's diagnoses included lumbar disc disease, lumbosacral sprain/strain, thoracic spine arthralgia, should sprain/strain, shoulder impingement, joint pain in the elbow, and ulnar nerve lesion. The patient's treatment recommendations included ulnar nerve transposition surgery with postoperative care to include a cold therapy unit and postoperative PT. Additional physical therapy for the lumbar spine was also recommended

IMR ISSUES, DECISIONS AND RATIONALES

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

POST-OPERATIVE COLD FLOW UNIT:

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

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

Decision rationale: The requested postoperative cold flow unit is not medically necessary or appropriate. Official Disability Guidelines do recommend the use of a continuous flow cryotherapy unit for postsurgical management of pain. However, it is recommended that the use of this device be limited to up to 7 days. The request as it is written does not specifically identify duration of treatment. Therefore, the appropriateness of this request cannot be determined. As such, the requested postoperative cold flow unit is not medically necessary or appropriate

ADDITIONAL PHYSICAL THERAPY FOR LUMBAR SPINE: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

Decision rationale: The requested additional physical therapy for the lumbar spine is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends that patients be transitioned into a home exercise program to maintain improvement levels obtained during skilled physical therapy. The clinical documentation does indicate that the patient previously received physical therapy for the lumbar spine. The clinical documentation fails to document that the patient is participating in a home exercise program. Therefore, 1 to 2 visits may be appropriate for this patient to re-establish and re-educate the patient in a home exercise program. However, the request as it is written does not clearly identify the duration of treatment. Therefore, the appropriateness of the request cannot be determined. As such, the requested additional physical therapy for the lumbar spine is not medically necessary or appropriate.