MAXIMUS Federal Services

Case Number:	CM14-0004842		
Date Assigned:	01/24/2014	Date of Injury:	02/03/2010
Decision Date:	06/09/2014	UR Denial Date:	12/18/2013
Priority:	Standard	Application Received:	01/10/2014

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 Physical Medicine and 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 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:

This 38 year-old male patient is a truck driver who sustained an injury on 2/3/10 while employed by [redacted]. Request(s) under consideration include purchase cold therapy unit. Diagnoses include lumbar intervertebral disc displacement without myelopathy. Previous care has include lumbar surgery disc arthroplasty 5/9/12, aquatic and physical therapy, medial branch blocks, medications, and off work. Report of 6/27/12 from the provider noted patient with severe lumbar spine pain with stabbing sensation in the right foot; cervical spine pain (not accepted body part); and bilateral knee pain from fall in September 2011 (not accepted body part). An exam showed mildly antalgic gait; decreased sensory on right S1 dermatome; tenderness on palpation of SI joints, paravertebral muscles without tenderness at flanks and coccyx; limited range of motion; 2+ symmetrial DTRs; and 5/5 motor strength with negative SLR. Impression noted total disc arthroplasty of 5/9/12 in good position (on x-rays). Medications list Prilosec, Percocet, Cymbalta, Restoril, and Oxycontin. Treatment for aquatic therapy with progression to land therapy, continued medications, and cold therapy unit. Report of 1/16/13 has unchanged symptoms complaints, clinical findings, with plan for medial branch blocks from L5-S1 for 1/25/13. The patient is now s/p radiofrequency neurotomy on 10/25/13 with request for purchase of cold therapy unit. It is not clear whether this cold therapy unit is for chronic low back complaints as records indicate use since 2012 lumbar surgery or is the for post RFA. Request(s) for purchase cold therapy unit was not medically necessary on 12/17/13 citing guidelines criteria and lack of medical necessity.

IMR ISSUES, DECISIONS AND RATIONALES

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

PURCHASE COLD THERAPY UNIT: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG),Cryotherapy/Cold/Heat Packs, Pages 381-382.

Decision rationale: This 38 year-old male truck driver sustained an injury on 2/3/10 while employed by [redacted]. Request(s) under consideration include purchase cold therapy unit. Diagnoses include lumbar intervertebral disc displacement without myelopathy. Previous care has include lumbar surgery disc arthroplasty 5/9/12, aquatic and physical therapy, medial branch blocks, medications, and off work. Report of 6/27/12 from the provider noted patient with severe lumbar spine pain with stabbing sensation in the right foot; cervical spine pain (not accepted body part); and bilateral knee pain from fall in September 2011 (not accepted body part). Exam showed mildly antalgic gait; decreased sensory on right S1 dermatome; tenderness on palpation of SI joints, paravertebral muscles without tenderness at flanks and coccyx; limited range of motion; 2+ symmetrial DTRs; and 5/5 motor strength with negative SLR. Impression noted total disc arthroplasty of 5/9/12 in good position (on x-rays). Medications list Prilosec, Percocet, Cymbalta, Restoril, and Oxycontin. Treatment for aquatic therapy with progression to land therapy, continued medications, and cold therapy unit. Report of 1/16/13 has unchanged symptoms complaints, clinical findings, with plan for medial branch blocks from L5-S1 for 1/25/13. The patient is now s/p radiofrequency neurotomy on 10/25/13 with request for purchase of cold therapy unit. It is not clear whether this cold therapy unit is for chronic low back complaints as records indicate use since 2012 lumbar surgery or is the for post RFA. Regarding Cold therapy, guidelines state it is "Recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use". The request for authorization does not provide supporting documentation for purchase beyond the guidelines criteria. There is no documentation that establishes medical necessity or that what is requested is medically reasonable outside recommendations of the guidelines. The request for a Cold therapy System purchase with Cold Therapy unit does not meet the requirements for medical necessity. MTUS Guidelines is silent on specific use of cold compression therapy, but does recommend standard cold pack for post exercise. ODG Guidelines specifically addresses the short-term benefit of cryotherapy post-surgery; however, limits the use for 7-day post-operative period as efficacy has not been proven after. The patient has history of lumbar surgery in 2012 and cold therapy unit purchase is not indicated for radiofrequency ablation. The purchase of cold therapy unit is not medically necessary and appropriate.