

Case Number:	CM14-0015177		
Date Assigned:	02/28/2014	Date of Injury:	01/28/2013
Decision Date:	06/27/2014	UR Denial Date:	01/30/2014
Priority:	Standard	Application Received:	02/06/2014

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 Orthopedic 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 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 55year old male who was injured on 01/28/2013. The patient experienced a very sharp pain in the right hip and leg when moving U-box from a load on 47 molder. Prior treatment history has included medications to include amitriptyline, hydrocodone and Chantix. Diagnostic studies reviewed include x-rays of pelvis dated 01/23/2014 showing no fracture or dislocation with degenerative joint disease. X-ray of lumbar spine dated 01/23/2014 shows L4-S1 mild degenerative disc disease. Orthopedic Consultation note dated 01/23/2014 documented the patient with complaints of right hip pain. The patient noticed the pain for months. The pain has been insidious in nature. The pain is at 8/10 and is sharp in nature. The pain is worse with walking and stairs. The patient states he has smoked twice in one week and I would like for him to quit before the surgery. Objective findings on examination of the right hip reveal tenderness in the groin and lateral trochanteric region. Motor strength 5/5. Hip flexion, extension and abduction strength 5/5. Range of motion flexion 90 degrees, extension -10 degrees, internal rotation 10 degrees and external rotation 0 degrees. Straight leg raise test is negative. UR report dated 01/30/2014 partially certified the requested Polar Care Unit and Cryo Cuff as medically necessary per ODG treatment Guidelines. The use of a Polar Care and Cryo Cuff is recommended for 7 days postoperatively.

IMR ISSUES, DECISIONS AND RATIONALES

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

POLAR CARE 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), Knee & Leg (Acute & Chronic), Continuous-flow cryotherapy

Decision rationale: California Medical Treatment Utilization Schedule (MTUS) American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) guidelines do not discuss the issue in dispute and hence ODG have been consulted. As per ODG, cryotherapy is "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." In this case, this patient has right hip pain with bone-on-bone hip DJD and the provider has requested total hip replacement. Thus, the use of polar care unit postop for up to 7 days is appropriate; however, it is unclear from the request whether the use of polar care unit is up to 7 days or more. Further clarification is needed regarding the intended use of polar care unit to determine medical necessity. The request is not medically necessary and appropriate.

CRYO CUFF: 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), Knee & Leg (Acute & Chronic), Continuous-flow cryotherapy

Decision rationale: Since it is unclear from the request whether the use of polar care unit is up to 7 days or more and is considered not medically necessary, the request for cryo cuff is also considered not medical necessary.