

Case Number:	CM14-0018921		
Date Assigned:	05/21/2014	Date of Injury:	11/14/2005
Decision Date:	08/01/2014	UR Denial Date:	01/29/2014
Priority:	Standard	Application Received:	02/14/2014

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:

This is a 66-year-old male patient with a 11/14/05 date of injury. 1/29/14 progress report indicates persistent low back pain, radicular pain and weakness. There is suspected instability at L4-5 and L5-S1. 12/19/13 progress report indicates right antalgic gait, markedly positive straight leg raise test on the right, positive straight leg raise test on the left. Treatment to date have included medication, lumbar decompression, acuity modification, physical therapy. 12/16/13 lumbar MRI demonstrates, at L4-5, moderate central canal stenosis, mild bilateral neural foraminal narrowing and marked bilateral ligamentum flavum hypertrophy and facet arthrosis. At L5-S1, there is evidence of prior right laminectomy and interval worsening of the right paracentral disk extrusion. There is moderate right and mild left neural foraminal narrowing with moderate bilateral facet arthrosis. The patient was certified for decompression of both L4-5 and L5-S1. There is documentation of a previous 1/29/14 adverse determination because the requesting provider indicated in a peer-to-peer conversation that he would forego the requested hot/cold therapy unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

HOT/COLD THERAPY UNIT WITH WRAP: 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 and Leg Chapter, Cryotherapy.

Decision rationale: CA MTUS does not address this issue. ODG states that continuous-flow 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. The patient was certified in a previous review to undergo L4-5 and L5-S1 decompression surgery. While continuous flow cryotherapy would be recommended for up to 7 days following surgical intervention, the request as submitted did not indicate a specific rental duration. Therefore, the request for a HOT/COLD THERAPY UNIT WITH WRAP as submitted was not medically necessary.