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| Case Number: | CM14-0164714 | | |
| Date Assigned: | 10/09/2014 | Date of Injury: | 12/30/2011 |
| Decision Date: | 11/10/2014 | UR Denial Date: | 09/24/2014 |
| Priority: | Standard | Application Received: | 10/07/2014 |

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 patient sustained an injury on 12/30/11 while employed by [REDACTED]. Request(s) under consideration include Cold therapy unit with pad, purchase. Diagnoses include lumbosacral intervertebral disc degeneration; spinal stenosis without neurogenic claudication; thoracic/ lumbosacral neuritis/ radiculitis; and status arthrodesis. Operative note of 9/16/14 noted patient underwent lumbar discectomy with decompression and fusion at L3-4 with interbody arthrodesis and plating. Peer review of 9/24/14 noted lumbar surgery has been recommended with request for shower bench, walker, and commode. Report of 10/2/14 noted from the provider noted the patient's low back pain is improved just 3 weeks after surgery with increased tolerance to ADLs and resolution of leg pain. Exam showed moderate pain and myospasm, incision healing well without infection. Treatment included Oxycontin and PT in future with patient remaining TTD until 12/17/14. The request(s) for Cold therapy unit with pad, purchase was non-certified on 9/24/14 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:

Cold therapy unit with pad, purchase: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back

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 patient sustained an injury on 12/30/11 while employed by [REDACTED]. Request(s) under consideration include Cold therapy unit with pad, purchase. Diagnoses include lumbosacral intervertebral disc degeneration; spinal stenosis without neurogenic claudication; thoracic/ lumbosacral neuritis/ radiculitis; and status arthrodesis. Operative note of 9/16/14 noted patient underwent lumbar discectomy with decompression and fusion at L3-4 with interbody arthrodesis and plating. Peer review of 9/24/14 noted lumbar surgery has been recommended with request for shower bench, walker, and commode. Report of 10/2/14 noted from the provider noted the patient's low back pain is improved just 3 weeks after surgery with increased tolerance to ADLs and resolution of leg pain. Exam showed moderate pain and myospasm, incision healing well without infection. Treatment included Oxycontin and PT in future with patient remaining TTD until 12/17/14. The request(s) for Cold therapy unit with pad, purchase was non-certified on 9/24/14. The patient underwent recent one level lumbar fusion on 9/16/14. 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 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 Cold therapy unit with pad, purchase is not medically necessary and appropriate.