

Case Number:	CM14-0020969		
Date Assigned:	04/30/2014	Date of Injury:	03/19/2012
Decision Date:	08/07/2014	UR Denial Date:	02/07/2014
Priority:	Standard	Application Received:	02/19/2014

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 Occupational Medicine 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:

Patient is a 41-year-old female who has submitted a claim for cervical sprain / strain, bilateral shoulder pain, thoracic sprain / strain, and bilateral wrist pain associated with an industrial injury date of 03/19/2012. Medical records from 2013 to 2014 were reviewed. Patient complained of upper back and neck pain radiating to both arms, associated with numbness and tingling sensation to the right hand. Spurling's maneuver was negative. Neer's, Tinel's, and Phalen's tests were positive at the right. Treatment to date has included physical therapy, chiropractic care, extracorporeal shockwave therapy, and medications. Utilization review from 02/07/2014 denied the requests for retro: contrast therapy system, 2 week rental; 12/9/13, retro: water circulating pad; 12/9/13, and retro: cold therapy wrap; 12/9/13 because at the time of service, patient was not in a post-operative state to necessitate the modality.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETROSPECTIVE REQUEST FOR CONTRAST THERAPY SYSTEM, 2 WEEK RENTAL; 12/9/13: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Aetna Clinical Policy Bulletin: Cryoanalgesia and Therapeutic Cold.

Decision rationale: The CA MTUS does not specifically address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers Compensation, the Aetna Clinical Policy Bulletin was used instead. Aetna considers the use of the Hot/Ice Machine and similar devices (e.g., the Hot/Ice Thermal Blanket, the TEC Thermoelectric Cooling System (an iceless cold compression device), the Vital Wear Cold/Hot Wrap, and the Vital Wrap) experimental and investigational for reducing pain and swelling after surgery or injury. Studies in the published literature have been poorly designed and failed to show that the Hot/Ice Machine offers any benefit over standard cryotherapy with ice bags/packs; and there are no studies evaluating its use as a heat source. In this case, there was no documented rationale for this modality. There was no discussion as to why this equipment is needed instead of standard passive hot and cold packs. Active hot and cold therapy units are not recommended as stated above. The guideline considers the device experimental and investigational for reducing pain and swelling after injury. The medical necessity was not established. Therefore, the request for retro: Contrast Therapy System, 2 Week rental; 12/9/13 is not medically necessary.

RETROSPECTIVE REQUEST FOR WATER CIRCULATING PAD, DISPENSED 12/9/13: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: The related request for contrast therapy system has been deemed not medically necessary; therefore, all of the associated services, such as this request for retro: Water Circulating pad; 12/9/13 was likewise not medically necessary.

RETROSPECTIVE REQUEST FOR COLD THERAPY WRAP; DISPENSED 12/9/13: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: The related request for contrast therapy system has been deemed not medically necessary; therefore, all of the associated services, such as this request for retro: Cold Therapy Wrap was likewise not medically necessary.