MAXIMUS Federal Services

Case Number:	CM14-0031334		
Date Assigned:	04/14/2014	Date of Injury:	03/19/2012
Decision Date:	05/27/2014	UR Denial Date:	01/02/2014
Priority:	Standard	Application Received:	01/31/2014

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, has a subspecialty in Pain Management 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 patient with a date of injury of 3/19/12. A utilization review determination dated 1/2/14 recommends non-certification of a thermocool unit and a home traction unit. 2/20/13 medical report identifies pain in the neck, upper and lower back, with some radiation into the BUE and down both legs. There is also bilateral shoulder, wrist, and hand pain with pins and needles in the arms and hands and trouble sleeping. On exam, there is cervical spasm and tenderness, positive Spurling's test, decreased sensation C6 and C7 on the right, positive Phalen's and Tinel's bilaterally, decreased shoulder ROM, lumbar spasm and tenderness, decreased lumbar ROM, positive SLR bilaterally at 80 degrees, any hypesthesia along the left L4 and S1 dermatomes and right L5 dermatome.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETROSPECTIVE REQUEST FOR 1 THERMOCOOL UNIT: 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 Official Disability Guidelines (ODG) Neck, Low Back, Shoulder, And Forearm, Wrist, And Hand Chapters, Continuous-Flow Cryotherapy.

Decision rationale: Regarding the request for a thermocool unit, California MTUS does not address the issue. ODG does support the use of continuous-flow cryotherapy for up to 7 days after surgery, but not for nonsurgical use. Within the documentation available for review, there is no documentation that the cryotherapy unit was intended/provided for postsurgical use. In the absence of such documentation, the currently requested thermocool unit is not medically necessary.

RETROSPECTIVE 1 HOME TRACTION UNIT: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back-Lumbar & Thoracic (Acute & Chronic).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 181-308.

Decision rationale: Regarding the request for a home traction unit, California MTUS states that traction is not recommended for the neck or low back. In light of the above issues, the currently requested home traction unit is not medically necessary.