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| Case Number: | CM14-0039586 | | |
| Date Assigned: | 06/27/2014 | Date of Injury: | 09/18/2012 |
| Decision Date: | 08/05/2014 | UR Denial Date: | 03/06/2014 |
| Priority: | Standard | Application Received: | 04/04/2014 |

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 & Rehabilitation, and is licensed to practice in Illinois. 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 injured worker is a 44-year-old male with reported date of injury on 09/18/2012. The mechanism of injury was not submitted within the medical records. His diagnoses thus far are noted to include bilateral lumbar radiculopathy, L5-S1 disc degeneration, C4-5 disc degeneration, C4-5 stenosis, bilateral cervical radiculopathy. His previous treatments were noted to include a lumbar support brace, physical therapy, and surgery. The progress note dated 06/03/2014 revealed that the injured worker complained of ongoing postoperative back and abdominal pain, but reported significant improvement since his last evaluation. The injured worker's lower extremity pain had resolved since the surgery. The injured worker complained of neck pain with radiation extending into bilateral upper extremities, rated 7/10. The physical examination of the lumbar spine and lower extremities revealed a normal gait with no evidence of weakness. There was a mild palpable tenderness in the paravertebral muscles bilaterally. A sensory examination revealed light touch and pin prick intact in the bilateral lower extremities. There is decreased range of motion noted and a right knee reflex was 3+, as the other 3 were 2+ and the motor strength was rated 5/5. The straight leg raise was negative. The request for authorization form dated 02/25/2014 was for a cold therapy unit 30 day rental and pneumatic intermittent compression device for postoperative utilization.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cold Therapy Unit- 30 day rental: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Cold/Heat packs.

Decision rationale: The Official Disability Guidelines recommend cold packs for the first few days of acute complaint; thereafter, application of heat packs or cold packs. Continuous cold therapy is superior to both acetaminophen and ibuprofen for treating low back pain. The evidence of application of cold treatment to low back pain is more limited than heat therapy, with only 3 poor quality studies located that support its use, but studies confirmed that it may be the lowest cost option. There is little evidence supporting the use of cold therapy, but heat therapy has been found to be helpful for pain reduction and return to normal function. The guidelines do not recommend cold therapy as an option for treating low back pain, and the surgery was 3 months ago, which does not warrant the need for cold therapy. Therefore, the request is not medically necessary.

Pneumatic Intermittent Compression Device: Upheld

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

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, Compression garments.

Decision rationale: The Official Disability Guidelines recommend compression garments due to good evidence for the use of compression if available, but little is known about the symmetry in compression, for how long, and for what level of compression should be applied. High levels of compression produced by bandaging and strong compression stockings are effective at healing leg ulcers and preventing progression of post-thrombotic syndrome as well as management of lymphedema. There was a lack of clinical findings to identify prophylactic issues relating to any deep vein thrombosis. The guidelines additionally recommend a compression garment for preventing progression of post-thrombotic syndrome which is not indicated in the injured worker's clinical findings. Therefore, the request is not medically necessary.