

Case Number:	CM14-0092407		
Date Assigned:	07/25/2014	Date of Injury:	10/17/2006
Decision Date:	09/30/2014	UR Denial Date:	06/13/2014
Priority:	Standard	Application Received:	06/18/2014

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 Texas. 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 60-year-old male who reported an injury on 10/17/2006 due to a 5 car pileup car accident, which occurred when the front vehicle failed to have break lights. The injured worker has diagnoses of cervical discogenic disease, cervical radiculitis, cervical facet syndrome, intractable left shoulder pain, status post left shoulder surgery, and status post cervical fusion at C4 to C7 level. Past medical treatment consists of surgery, physical therapy, and medication therapy. Medications included Zanaflex, Kadian, oxycodone, and Losartan. An MRI of the cervical spine was obtained on 01/10/2013. An EMG/NCV was obtained on 01/26/2010. The injured worker underwent lower back surgery in 1984, 1995, and again in 1997. The injured worker also underwent neck and carpal tunnel surgery in 2008. He went on to have shoulder and carpal tunnel surgery again in 2009. On 05/27/2014, the injured worker complained of upper extremities radiculopathy pain. Physical examination of the neck revealed spasm, guarding and loss of lordosis. Rotation to the right was 45 degrees, left was 30 degrees with pain of a Lhermitte's type into the interscapular and left cervicothoracic region. Flexion was 45 degrees, extension was 0 degrees. Extension at 0 to 5 degrees caused left cervicothoracic Lhermitte's sign. Abduction to the right was 30 degrees, left was 10 degrees. Abduction to the right caused right cervicothoracic pain, and to the left also caused cervicothoracic pain. The injured worker held his neck in a neutral anterior forward 5 degrees and flexed 20 degrees with rotation to the right 20 degrees in the neutral position. The sensory examination showed left greater than right C4, C5, C6 and C7 dermatomal loss, left greater than right. This appeared to be more in the C5-6 distribution than the C6-7 distribution. Motor strength examination revealed a 4/5, 60% to 80% of normal catch-give type weakness secondary to pain and guarding on the left deltoid, left biceps, triceps, and left grip. Tinel's was positive on the left and negative on the right. The

medical treatment plan is for the injured worker to have use of an Inter limb compression device. The rationale and Request for Authorization form were not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Inter limb Compression Device: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines- Neck and Upper Back; Collars.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee, Continuous-flow cryotherapy.

Decision rationale: The request for Inter limb Compression Device is not medically necessary. ODG recommend continuous flow cryotherapy as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. In the postoperative setting, continuous flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage; however, the effect on more frequently treated acute injuries has not been fully evaluated. Continuous flow cryotherapy units provide regulated temperatures through use of power to circulate ice water in the cooling packs. The available scientific literature is insufficient to document the use of continuous flow cooling systems in association with a benefit beyond convenience and patient compliance in the outpatient setting. Mechanically circulating units with pumps have not been proven to be more effective than passive hot and cold therapy. This study concluded that continuous cold therapy devices, compared to simple icing, resulted in much better night time pain control and improved quality of life in the early period following routine arthroscopy. Given the above, the injured worker is not within the Official Disability Guidelines' recommendations. The submitted report did not indicate that the injured worker had undergone recent knee therapy. According to guidelines, it is not recommended for nonsurgical treatment. As such, the request for an Inter limb Compression Device is not medically necessary.