

<b>Case Number:</b>	CM13-0037314		
<b>Date Assigned:</b>	12/13/2013	<b>Date of Injury:</b>	11/04/2009
<b>Decision Date:</b>	01/16/2015	<b>UR Denial Date:</b>	09/20/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/23/2013

### 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 New York. 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 patient is a 47-year-old with left arm pain and bilateral ankle pain left leg pain and neck pain. The patient has had pain medication and physical therapy. On physical examination the patient has tenderness to the cervical spine and left arm. Sensation is decreased in the left upper extremity. There is a decreased range of neck motion. The patient is diagnosed with question of cervical radiculopathy with spinal stenosis. The date of injury is November 4, 2009. MRI the cervical spine shows disc protrusion at C4-5 there is degenerative disc disease at C6-7. There is foraminal stenosis at C6-7. X-ray shows degenerative disc condition at C6-7. The patient has neurophysiologic testing which did not show documented radiculopathy. Patient has had C6 epidural steroid injection. Patient has been indicated for surgery. At issue is whether cold therapy is medically needed.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**PURCHASE OF POST-OPERATIVE COLD THERAPY VASCUTHERM UNIT:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 181-183. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back; Forearm, Wrist and Hand; Shoulder

**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: ODG neck pain chapter , MTUS neck pain chapter

**Decision rationale:** This injured worker does not meet criteria for cold therapy. Injured worker has been indicated for cervical spine surgery. Guidelines do not support the use of cold therapy after cervical spine surgery. Medical literature does not demonstrate improved outcomes of cold therapy after spine surgery. Cold therapy is not recommended. Guidelines do not support the use of cold therapy after neck surgery according to MTUS neck pain chapter. The request is not medically necessary.

**ORTHOFIX:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back, Bone-growth stimulators (BGS)

**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:

**Decision rationale:** Guidelines do not support the use of bone to stimulate after single level cervical fusion surgery. In addition the medical records do not document any risks factors for nonunion. Guidelines for the use of bone growth stimulator are not met. The request for a Bone growth stimulator is not medically necessary.