

Case Number:	CM14-0183390		
Date Assigned:	01/07/2015	Date of Injury:	02/01/2010
Decision Date:	02/10/2015	UR Denial Date:	10/30/2014
Priority:	Standard	Application Received:	11/04/2014

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 Spine Surgery 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:

Section 1: The injured worker is a 69-year-old female who reported an injury on 02/01/2010. The mechanism of injury was a trip and fall. Her relevant diagnoses included contusion of the spine, thoracic; contusion of the left knee; head contusion; bilateral contusions of the hands; and contusion of the lower left leg. Her past treatments have included pain medication, physical therapy, bracing, crutches, and cane. Her diagnostic studies included x-rays and an MRI of the cervical spine on 09/22/2014 that revealed C3-4 small central disc protrusion, a C4-5 central disc herniation, a C5-6 marked disc degeneration, and C6-7 uncovertebral spurring. The surgical history included a left knee replacement on 12/14/2011. The progress noted dated 09/23/2014 documented that the injured worker had complaints of severe pain in the low back that radiated to the left leg and moderate pain in the neck which radiated into the left shoulder and arm. On physical examination, the injured worker was severely limited in range of motion in the thoracolumbar spine. Forward flexion was 20 degrees, extension was 10 degrees, and lateral bending was 5 degrees. A straight leg raise was positive on the left and negative on the right. Her medications were not included in the medical records. The treatment plan was not included. The rationale for the request was not included. The Request for Authorization form was not included.

IMR ISSUES, DECISIONS AND RATIONALES

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

Associated surgical service: Hot/cold therapy unit with wrap, purchase: 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 & Upper Back (updated 08/04/14)

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

Decision rationale: The request for hot/cold therapy unit with wrap, purchase, is not medically necessary. The injured worker stated her primary complaint was low back pain radiating into the left buttock and leg and her secondary complaint was pain in the back of her head and neck, radiating into the left shoulder and arm. The California MTUS Guidelines 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. The request does not indicate what body part the hot/cold therapy unit with wrap will be used for. However, the Official Disability Guidelines do not recommend purchase, as it is only recommended for postoperative use up to 7 days. Therefore, the request for the hot/cold therapy unit with wrap, purchase is not medically necessary.

Associated surgical service: Bone growth stimulator, purchase: 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 & Upper Back (updated 08/22/14)

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

Decision rationale: The Official Disability Guidelines state that bone growth stimulators can be classified into 2 groups: electromagnetic or ultrasound. Electromagnetic stimulators are further divided into inductive, otherwise known as pulsed electromagnetic fields, or capacitive coupling devices. According to the systemic review, for treatment of delayed unions and nonunions, direct current, pulsed electromagnetic fields, and low intensity pulsed ultrasound, bone stimulators are selectively recommended due to small benefit while capacitive current technology is recommended more strongly. An electrical bone stimulator uses electric current to promote bone healing. Direct current electrical bone growth stimulators may be appropriate for nonunions, failed fusions, and congenital pseudoarthrosis where there is no evidence of progression of healing for 3 or more months, despite appropriate fracture care. The documentation submitted for review did not indicate what type of bone growth stimulator was being requested, nor does it indicate where the stimulator will be used. The documentation submitted for review did not indicate if there was callus formation; there was no documentation of serial x-rays to confirm the signs of nonhealing; if the fracture gap 1 cm or less; or if the fracture been adequately immobilized. Due to the lack of documentation to support the request, the request is not medically necessary.

