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| Case Number: | CM14-0198473 | | |
| Date Assigned: | 12/08/2014 | Date of Injury: | 12/20/2012 |
| Decision Date: | 01/21/2015 | UR Denial Date: | 10/30/2014 |
| Priority: | Standard | Application Received: | 11/25/2014 |

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 Georgia. 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 who reported injury on 12/20/2012. The mechanism of injury was not submitted for review. The injured worker has a diagnosis of chronic pain, lumbar disc displacement, lumbar postlaminectomy syndrome, lumbar radiculopathy, lumbar spondylolisthesis and status post lumbar discectomy. Past medical treatment consists of surgery, DVT max unit, ESIs, physical therapy and medication therapy. Medications consist of clonazepam, Gabapentin, Norco, Omeprazole, Sertraline, and Trazodone. On 07/10/2014, the injured worker underwent an EMG/NCS which revealed no evidence of peripheral neuropathy or lumbar radiculopathy. On 01/07/2013, the injured worker underwent an MRI of the lumbar spine without contrast which revealed: L5-S1, a 4 mm anterior subluxation of L4 upon L5; bilateral pars interarticularis defects of L5 which contribute to spondylolisthesis. It is documented in the report that the injured worker is status post lumbar discectomy. However, it does not indicate the date surgery was performed. On 11/10/2014, the injured worker was seen on a follow-up visit and complained of low back pain. The injured worker stated that the pain radiated to the knees and heels, at times the pain also radiated to the testicles. He described the pain as dull, sharp, stabbing and severe in severity. He rated the pain at a 7/10 intensity with medications, and 8/10 without medications. Physical examination of the lumbar spine revealed spasm noted at L4-S1. Tenderness was noted upon palpation in the spinal vertebral area L4-S1 levels. Range of motion of the lumbar spine was severely limited secondary to pain. Pain was significantly increased with bending to the left, bending to the right, flexion and extension. Sensory exam showed decreased sensitivity to touch along the L5-S1 dermatome and bilateral lower extremities. Straight leg raise with the patient in the seated position was positive bilaterally at 70 degrees. The treatment plan is for the injured worker to continue with medication therapy. 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:

Motorized Cold Unit: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Am J Sports Med. 2004 pages 251-261

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 Motorized Cold Unit is not medically necessary. The Official Disability 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. 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 that the use of continuous flow cooling therapy is associated with a benefit beyond convenience and patient compliance in the outpatient setting. The documentation indicated that the injured worker was postop. However, it did not indicate when the injured worker had the lumbar discectomy. The Official Disability Guidelines recommend the use of continuous flow cryotherapy postoperatively generally up to 7 days. The request as submitted did not indicate a frequency or a duration for the unit, nor did it specify if the unit was for rental or for purchase. Additionally, it is unclear how the injured worker would not benefit from ice packs versus the motorized cold unit. Furthermore, there was no rationale submitted to warrant the request for the motorized cold unit. Given the above, the injured worker is not within the ODG recommended guideline criteria. As such, the request is not medically necessary.