MAXIMUS Federal Services

Case Number:	CM14-0199237		
Date Assigned:	12/09/2014	Date of Injury:	03/04/2009
Decision Date:	01/28/2015	UR Denial Date:	11/03/2014
Priority:	Standard	Application Received:	11/26/2014

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 Occupational Medicine 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:

This is a 57 year old female who sustained a work related injury on March 4, 2009 while working as a police officer. The injured worker slipped on a wet surface, fell and sustained a back and head injury. An orthopedic consultation dated June 11, 2009 notes that Initial treatments included x-rays, pain medication, physical therapy, acupuncture and physical therapy. Diagnoses included a cervical stain/sprain with a positive MRI for disc herniation and a lumbosacral sprain/strain with MRI evidence of grade one spondylolisthesis at the lumbar five-sacral one levels with disc disease. Other diagnoses included recurrent left carpal tunnel syndrome and post cervical bilateral carpal tunnel decompressions and ulnar nerve transposition. Work status is permanent and stationary. Current documentation dated October 14, 2014 notes that the injured worker reported ongoing upper back and neck pain which radiated into the left arm. Pain level was rated at a ten out of ten without medication and a five out of ten with medications. Physical examination revealed paracervical muscle tenderness, tenderness over the paravertebral muscle area of the thoracic spine, significant tenderness over the left trochanteric area and minimal tenderness over the lumbosacral spine. Sensation was decreased over the cervical spine. Spurling's test and a cervical axial traction test were positive. Current diagnoses include neck pain with radicular symptoms to the left upper extremity, MRI findings of disc protrusions of the cervical three through cervical seven levels with left-sided neuroforaminal narrowing and a history of a right lumbar rhizotomy in the lumbar area done July 22, 2014 and a left lumbar rhizotomy which was done on November 27, 2013. The injured worker underwent trigger point injections into the upper thoracic and lower cervical regions during the visit with immediate relief. The treating physician requested a motorized cold therapy unit for use following cervical epidural steroid injections. Utilization Review evaluated and denied the request on November 3, 2014. The Official Disability Guidelines, Neck and Upper Back (Acute

&Chronic) were referenced and state that continuous flow cryotherapy is not recommended for the neck. Therefore, the request for a motorized cold therapy unit is non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Motorized cold therapy unit: 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 (Acute & Chronic)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck, Shoulder; Continuous Cold Therapy

Decision rationale: MTUS Guidelines do not address this issue. ODG directly address this issue and do not recommend continuous cold therapy for the cervical spine. The shoulder chapter provides additional details where it use is recommended for a limited number of days post major joint surgery. This individual does not meet guideline standards for this request and there are no unusual circumstances to justify an exception to guidelines. The motorized cold therapy unit is not medically necessary.