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| Case Number: | CM14-0082305 | | |
| Date Assigned: | 07/21/2014 | Date of Injury: | 01/24/2001 |
| Decision Date: | 02/17/2015 | UR Denial Date: | 04/30/2014 |
| Priority: | Standard | Application Received: | 06/03/2014 |

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 Physical Medicine Rehab, has a subspecialty in Interventional spine 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:

The patient is a 61 year old female with an injury date of 01/24/01. The most recent report provided is dated 02/19/14; however, no examination findings or diagnoses are provided. The 11/20/13 report states there is a need for surgery or hospitalization and that the patient presents with neck lower back, bilateral shoulder and bilateral wrist/hand pain. The examination states, "+2 tenderness c/s, l/s". The patient's diagnoses include: 1. S/p lumbar spinal fusion surgery (10/17/03) 2. S/p right shoulder surgery x 1 (10/18/01) 3. Cervical spine disc bulge 4. S/p right carpal tunnel surgery 5. Left shoulder internal derangement 6. Left carpal tunnel syndrome. The utilization review dated 04/30/14 denied the request as there is no evidence of post-surgical conservative care to warrant a vasopneumatic device or lymphedema pump nor is there evidence based literature to support a motorized unit over conventional cold therapy beyond convenience. Reports were provided for review from 11/20/13 to 02/19/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Vascutherm back wrap for purchase: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) - Treatment for Workers' Compensation, Online Edition, Chapter: Low Back, Cryotherapy

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg Chapter, Cold compression therapy.

Decision rationale: The patient presents with pain in the neck, lower back, bilateral shoulders and bilateral wrists/hands. The current request is for Vascutherm back wrap for purchase per 11/22/13 RFA. This request is associated with the request for a vascutherm unit which is discussed below. ODG, Knee and Leg Chapter, Cold compression therapy, does not discuss the vascutherm unit. Under the Game Ready accelerated recovery system it states that this unit combines continuous flow cryotherapy with the use of vaso-compression. ODG. Continuous-flow cryotherapy, states, "Recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use." Guidelines do not discuss use for the back. The treater does not discuss the reason for this request in the reports provided. The most recent report dated 02/19/14 states under "DME other" the request is cold pneumatic compression, per RFA of 11/22/13. The RFA states the request is for a diagnosis of Lumbar spine fusion cervical spine disc bulge. Discussion by the 04/30/14 utilization review indicates the request may be for post-operative treatment; however, there is no evidence in the utilization review or the reports provided that the patient is in a post-operative period. In this case, the reports provided do not clearly state this request, guidelines support 7 days postoperative use and the request is for a 30 day rental, there is no evidence use is post-operative, and guidelines do not support use for the back or non-surgical treatment. The request is not medically necessary.

Vascutherm unit for rental for 30 days: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) - Treatment in Workers' Compensation, Online Edition, Chapter Low Back, Cryotherapy

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg Chapter, Cold compression therapy.

Decision rationale: The patient presents with pain in the neck, lower back, bilateral shoulders and bilateral wrists/hands. The current request is for Vascutherm unit for rental for 30 days per RFA of 11/22/13. ODG, Knee and Leg Chapter, Cold compression therapy, does not discuss the vascutherm unit. Under the Game Ready accelerated recovery system it states that this unit combines continuous flow cryotherapy with the use of vaso-compression. ODG. Continuous-flow cryotherapy, states, "Recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use." Guidelines do not discuss use for the back. The treater does not discuss the reason for this request in the reports provided. The most recent report dated 02/19/14 states under "DME other" the request is cold pneumatic compression, per RFA 11/22/13. The RFA states the request is for a diagnosis of Lumbar spine fusion cervical spine disc bulge. Discussion by the 04/30/14 utilization review indicates the request may be for post-operative treatment; however, there is no evidence in the utilization review or the reports provided that the patient is in a post-operative period. In this

case, the reports provided do not clearly state this request, guidelines support 7 days postoperative use and the request is for a 30 day rental, there is no evidence use is post-operative, and guidelines do not support use for the back or non-surgical treatment. The request is not medically necessary.