

Case Number:	CM15-0187944		
Date Assigned:	09/29/2015	Date of Injury:	08/21/2012
Decision Date:	11/09/2015	UR Denial Date:	09/22/2015
Priority:	Standard	Application Received:	09/24/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: California, Oregon, Washington
 Certification(s)/Specialty: Orthopedic Surgery

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 48 year old female who sustained an industrial injury on 8-21-12. A review of the medical records indicates she is undergoing treatment for chronic pain syndrome, lumbar sprain and strain, displacement of cervical intervertebral disc without myelopathy, cervical radiculopathy, and brachial neuritis or radiculitis. She is status post anterior cervical discectomy and fusion of C4-C7 on 9-1-15. Medical records (3-30-15 to 9-15-15) indicate ongoing complaints of "severe" neck pain, bilateral arm pain with numbness, and lower back pain. On the postoperative visit (9-8-15), she complained of neck and back pain with radiation to bilateral shoulders and bilateral legs. She has rated her pain "10 out of 10" without the use of medications and "9 out of 10" with the use of medications. The pain rating is noted to be the same before and after surgery. The physical exam (9-8-15) reveals a hard cervical collar in place. The incisional dressing is clean, dry, and intact. "Severe" decreased range of motion of the cervical spine is noted. Prior to surgery, the physical exam (8-10-15) revealed "5 out of 5" bilateral upper extremity strength, "severe" palpable spasms bilateral cervical paraspinal musculature with positive twitch response - right greater than left, positive Spurling's on the left, positive axial compression maneuver, and "severe" decreased range of motion of the cervical spine. Diagnostic studies have included x-rays of the cervical spine, an MRI of the lumbar spine, and an MRI of the cervical spine, showing "severe spinal stenosis C4-5 and C5-6 with cord indentation". Treatment prior to surgery has included physical therapy, chiropractic treatments, and medications. The request for authorization (9-15-15) includes "INT cold compression and cervical wrap -set up and delivery." The utilization review (9-22-15) indicates denial of the requested treatment.

IMR ISSUES, DECISIONS AND RATIONALES

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

Int. Cold compression unit x30 day rental (cervical): Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back (updated 6/25/15), continuous-flow cryotherapy.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper back regarding continuous flow cryotherapy.

Decision rationale: CA MTUS/ACOEM is silent on the issue of continuous flow cryotherapy. According to the ODG Neck and Upper back regarding continuous flow cryotherapy, it is not recommended in the neck. Local application of cold packs is recommended by the ODG Neck and Upper Back section. Therefore determination is not medically necessary for the requested cold therapy vascultherm post surgical procedure.

Cervical wrap for purchase: Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back (updated 6/25/15), continuous-flow 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 section, Compression Garments.

Decision rationale: CA MTUS/ACOEM is silent on the issue of DVT compression garments. The ODG, Knee and Leg section, Compression Garments, summarizes the recommendations of the American College of Chest Physicians and American Academy of Orthopedic Surgeons. It is recommend to use of mechanical compression devices after all major knee surgeries including total hip and total knee replacements. In this patient there is no documentation of a history of increased risk of DVT or major knee surgery. The patient underwent a routine knee arthroscopy. Therefore medical necessity cannot be established and therefore the determinations for non-certification for the requested device. The use of an outpatient pneumatic compression device is not medically necessary, as it is not in accordance with nationally accepted standards of medical practice. While the use of a pneumatic compression device is clinically appropriate in an inpatient setting, their utility has not been demonstrated in an outpatient setting once the postoperative total knee arthroplasty patient is ambulatory.

