

Case Number:	CM15-0049501		
Date Assigned:	03/23/2015	Date of Injury:	03/21/2011
Decision Date:	05/06/2015	UR Denial Date:	02/24/2015
Priority:	Standard	Application Received:	03/16/2015

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: Illinois, California, Texas
 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 58-year-old male who sustained an industrial injury on 3/21/11. Injuries were reported to the bilateral knees, upper extremities, and feet, neck, low back and left ankle from 7/3/81 to 3/21/11 relative to his employment as a fire fighter. Past surgical history was positive for left shoulder arthroscopic subacromial decompression and debridement on 7/11/11, and right shoulder arthroscopy with rotator cuff repair on 10/21/11. The 10/1/14 cervical spine MRI revealed a 3-4 mm C4/5 disc protrusion with narrowed disc space and central canal and foraminal stenosis. The disc touched the cord at the C4/5 level with no cord compression seen. At the C5/6 level, there was disc desiccation with 2-3 mm annular bulge with biforaminal and mild central canal stenosis. The 2/3/15 treating physician report cited intermittent, moderate to severe cervical pain radiating through both shoulders to the hands, left greater than right, with associated numbness and paresthesia throughout his bilateral upper extremities. Physical exam documented cervical paraspinal tenderness to palpation, decreased left C6 and C7 dermatomal sensation, decreased left upper extremity strength, and absent left biceps and brachioradialis reflexes. CT scan findings showed bone-on-bone decreased disc height with severe bilateral foraminal stenosis at the C4/5 and C5/6 levels. Authorization was requested for C4/5 and C5/6 anterior cervical discectomy and fusion, along with Aspen collar, assistant surgeon, pre-operative medical clearance, cryotherapy, and TENS unit purchase. The 2/23/15 utilization review certified the request for anterior cervical discectomy and fusion at C4/5 and C5/6, with assistant surgeon, Aspen collar, and pre-operative medical clearance. The request for TENS unit purchase and cryotherapy unit was non-certified. The rationale for non-certification of the TENS unit purchase

indicated that 30-days post-operative use was an option but there was no evidence that the patient would be unable to tolerate an exercise program, fail post-op conservative care, or that multimodality care was indicated. The rationale for non-certification of the cryotherapy unit was based on the absence of guideline support for a specialized unit over standard ice packs.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cryotherapy: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 181. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 174. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back, Continuous-flow cryotherapy.

Decision rationale: The California MTUS are silent regarding cold therapy devices, but recommend at home local applications of cold packs. The Official Disability Guidelines do not recommend the use of continuous flow cryotherapy in the neck. There is insufficient evidence to support the efficacy of a cold therapy unit over standard cold packs. There is no compelling reason submitted to support the medical necessity of a cryotherapy unit in the absence of guideline support. Therefore, this request is not medically necessary.

TENS Unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 116-117.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS, post-operative pain (transcutaneous electrical nerve stimulation) Page(s): 116-117.

Decision rationale: The California MTUS guidelines recommend TENS use as a treatment option for acute post-operative pain in the first 30 days after surgery. TENS appears to be most effective for mild to moderate thoracotomy pain. It has been shown to be of lesser effect, or not at all for other orthopedic surgical procedures. Guidelines state that the proposed necessity of the unit should be documented. Guidelines have not been met. The patient was scheduled for anterior cervical discectomy and fusion. There is no indication that standard post-op pain management would be insufficient. There is no documentation that the patient was intolerant or unresponsive to pain medications during the pre-operative period. Additionally, this request is for purchase which exceeds guideline recommendations for 30-day post-op use. Therefore, this request is not medically necessary.

