

Case Number:	CM15-0083293		
Date Assigned:	05/05/2015	Date of Injury:	05/08/2008
Decision Date:	06/17/2015	UR Denial Date:	04/27/2015
Priority:	Standard	Application Received:	04/30/2015

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

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 65 year old female who sustained an industrial injury on 5/8/08. The injured worker was diagnosed as having lumbar radiculopathy, hip pain, sacroiliitis, sacroiliac pain, low back pain and disorder of coccyx. Currently, the injured worker was with complaints of lower back and left hip pain. Previous treatments included injections, coccyx donut pillow, physical therapy, home exercise program, functional restoration program, and medication management. Previous diagnostic studies included magnetic resonance imaging, radiographic studies, and electromyography and nerve conduction studies. The injured workers pain level was noted as 5/10 with pain medications and an 8/10 without pain medications. Physical examination was notable for lumbar spine with restricted range of motion and tenderness noted upon palpation, left hip with restricted range of motion due to pain and tenderness noted over the groin, sacroiliac joint and trochanter. The plan of care was for a cold therapy unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

DME durable medical equipment - 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: Knee & Leg chapter - Continuous flow cryotherapy.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Knee and Leg Chapter, Continuous flow cryotherapy.

Decision rationale: CA MTUS/ACOEM is silent on the issue of cryotherapy. According to ODG, Knee and Leg Chapter regarding continuous flow cryotherapy it is a recommended option after surgery but not for nonsurgical treatment. It is recommended for upwards of 7 days postoperatively. In this case the request is for an unknown quantity of days. Therefore the determination is not medically necessary.