MAXIMUS Federal Services

Case Number:	CM14-0123980		
Date Assigned:	08/08/2014	Date of Injury:	11/09/2013
Decision Date:	09/29/2014	UR Denial Date:	07/28/2014
Priority:	Standard	Application Received:	08/05/2014

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 and Rehabilitation and is licensed to practice in Louisiana. 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 62 year old male who was injured on 11/09/2013. The mechanism of injury is unknown. Prior medication history included Cyclobenzaprine, Diclofenac, and Norco. The patient underwent arthroscopy of right hip with labral repair on 08/18/2014. Diagnostic studies reviewed include x-ray of the right hip dated 11/11/2013 revealed an intact right hip. Progress report dated 08/12/2014 indicates the patient presented for pre-operative stabilization with regard to his right hip/groin pain that has not improved with steroid injection. He reported continued dysfunction. On exam, the left groin revealed discomfort mainly. Bounding pulses are present and he has fairly good strength although with hip flexion, he had discomfort which leads to early fatigue. He has a labral tear of the right hip. He was recommended for polar care cold therapy unit.Prior utilization review dated 07/28/2014 states the request for Durable Medical Equipment (DME) Purchase Polar Care-Cold Therapy Unit is denied as medical necessity has not been established.

IMR ISSUES, DECISIONS AND RATIONALES

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

Durable Medical Equipment (DME) Purchase Polar Care-Cold Therapy Unit: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation http://www.breg.com/sites/default/files/downloads/prod-files/Kodiak-Cube-Glacier-IFU-1_00372B_1.pdfhttp://www.cms.gov/Center/Provider-Type/Durable-Medical-Equipment-DME-Center.html.

Decision rationale: Durable Medical Equipment suppliers and physicians who order certain DME items will continue to collaborate and establish internal processes to ensure compliance with the face-to-face requirement with appropriate documentation. A screening should be conducted for risk factors before prescribing cold therapy. In this case, there is no supporting documentation that will benefit from this treatment therefore, the request for a Durable Medical Equipment (DME) Purchase Polar Care-Cold Therapy Unit is not medically necessary at this time.