

Case Number:	CM14-0129556		
Date Assigned:	08/20/2014	Date of Injury:	09/29/2010
Decision Date:	10/21/2014	UR Denial Date:	07/21/2014
Priority:	Standard	Application Received:	08/14/2014

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 Nevada. 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 injured worker is a 58-year-old male who was reportedly injured on 9/29/2010. The most recent progress note dated 5/17/2014, indicated that there were ongoing complaints of low back pain that radiated into the left lower extremity. The physical examination was from 4/3/2014. Cervical spine had positive tenderness about the paracervical and trapezius muscles. There was positive cervical distraction test. Muscle spasms were noted. Restricted range of motion was due to pain. Lumbar spine revealed increased tone and tenderness about the paralumbar musculature, with tenderness at the midline thoracolumbar junction, and over the level of L5-S1 facets and right greater sciatic notch. Positive muscle spasms noted. Diagnostic imaging studies included a magnetic resonance image of the lumbar spine, dated 5/17/2014, which revealed L3-L4 moderate right-sided and mild to moderate left-sided neural foraminal stenosis and spinal canal stenosis. L5-S1 neural foraminal stenosis noted. Previous treatment included medications, cervical fusion and conservative treatment. A request was made for cryotherapy 2 x 6 and was not certified in the pre-authorization process on 7/21/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cryotherapy twice a week for six weeks: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG -TWC/ODG Integrated Treatment/Disability Duration Guidelines; Shoulder (Acute & Chronic) - Continuous Flow Cryotherapy - (updated 7/29/14) (electronically cited)

Decision rationale: Cryotherapy is recommended as an option after surgery but not for nonsurgical treatment. Postoperative use generally may be up to 7 days including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage; however, the effect on more frequently treated acute injuries (eg, muscle strains and contusions) has not been fully evaluated. After review of the medical records provided, the claimant is status post cervical fusion greater than seven days. There is no significant documentation for the justification for this treatment based on the physical exam findings and history present illness. Therefore, the request for cryotherapy twice a week for six weeks is not medically necessary and appropriate.