

Case Number:	CM14-0147799		
Date Assigned:	09/15/2014	Date of Injury:	11/27/2012
Decision Date:	10/29/2014	UR Denial Date:	08/22/2014
Priority:	Standard	Application Received:	09/11/2014

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, has a subspecialty in Pain Medicine and is licensed to practice in California. 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:

This is a patient with a date of injury of November 27, 2012. A utilization review determination dated August 22, 2014 recommends non-certification of a cold water circulating pump. A utilization review determination dated August 20, 2014 recommends non-certification for an L4-5 and L5-S1 micro discectomy. A progress report dated July 24, 2014 identifies subjective complaints of low back pain radiating into both legs. Physical examination findings reveal increased tone and tenderness around their lumbar musculature with decreased range of motion. The patient has decreased sensation in the left L5 and S1 distribution. Diagnoses include anterolisthesis of L4 on L5 and L3-4 broad posterior disc bulge. The treatment plan recommends a micro discectomy, postoperative cryotherapy twice a week for 6 weeks and postoperative physical therapy. A progress report dated August 15, 2014 recommends posterior instrumentation infusion from T10-L4.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cryotherapy unit for lumbar spine post-operative- unspecific if purchase or rental: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back: Laminectomy/laminotomy

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Cold/Heat Packs

Decision rationale: Regarding the request for a Cryotherapy unit for lumbar spine post-operative, California MTUS and ODG do not specifically address the issue for the low back, although ODG supports cold therapy units for up to 7 days after surgery for some other body parts. For the back, CA MTUS/ACOEM and ODG recommend the use of cold packs for acute complaints. Within the documentation available for review, there is no documentation of a rationale for the use of a formal cold therapy unit rather than the application of simple cold packs at home during the initial postoperative period. Additionally, there is no duration associated with the request, and there is no provision to modify the current request. Additionally, the surgical procedure for which this request was made has been recommended for non-certification. As such, the currently requested Cryotherapy unit for lumbar spine post-operative is not medically necessary.