

Case Number:	CM14-0171365		
Date Assigned:	10/23/2014	Date of Injury:	01/20/1993
Decision Date:	11/25/2014	UR Denial Date:	10/08/2014
Priority:	Standard	Application Received:	10/16/2014

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 Orthopedic Spine Surgeon and is licensed to practice in Texas. 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 65-year-old male who reported an injury on 01/20/1993. The mechanism of injury involved a fall. The current diagnoses include L2-3 and L3-4 moderately severe stenosis, L3-4 grade 2 spondylolisthesis, neurogenic claudication, and status post L4-5 laminectomy and fusion. The injured worker was evaluated on 09/26/2014 with complaints of persistent lower back pain, neck pain, and radiation into the right shoulder and upper arm. Previous conservative treatment is noted to include physical therapy, TENS therapy, and medications. The physical examination revealed tenderness to palpation over the bilateral cervical paraspinal musculature, bilateral trapezius tenderness, bilateral interscapular space tenderness, limited cervical range of motion, decreased sensation over the C7-T1 dermatomal distributions, diminished upper extremity strength bilaterally, 1+ deep tendon reflexes bilaterally, tenderness to palpation over the lower midline lumbar spine, bilateral sacroiliac joint tenderness, decreased sensation over the right L4 dermatomal distribution, hyperesthesia over the right S1 dermatomal distribution, limited lumbar range of motion, and diminished motor strength in the right lower extremity. Treatment recommendations at that time included authorization for a C3-4 discectomy and fusion with cage and instrumentation. There was no Request for Authorization form submitted for this review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cold Therapy Unit (30 Day 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, Neck, Continuous-Flow Cryotherapy.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck & Upper Back Chapter, Continuous Flow Cryotherapy.

Decision rationale: The Official Disability Guidelines do not recommend continuous flow cryotherapy for the neck. It has been recommended as an option after shoulder surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days. There is no indication that this injured worker's requested surgical procedure has been authorized. Therefore, the request for postoperative durable medical equipment is not medically necessary at this time. Additionally, the Official Disability Guidelines do not recommend continuous flow cryotherapy for the cervical spine. As such, the request for a Cold Therapy Unit is not medically necessary.