

Case Number:	CM14-0198706		
Date Assigned:	12/09/2014	Date of Injury:	05/01/2010
Decision Date:	01/26/2015	UR Denial Date:	10/27/2014
Priority:	Standard	Application Received:	11/26/2014

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 Spine Surgery, 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:

The injured worker is a 42-year-old male who reported an injury on 05/01/2010. The mechanism of injury was not specified. His diagnoses included lumbar disc disease. Past treatments were noted to include surgery and physical therapy. Diagnostic studies included x-ray of the lumbar spine performed on 10/03/2014, which noted a normal lumbosacral spine; and an MRI of the lumbar spine performed on 10/03/2014, which noted moderate facet arthrosis and small foraminal disc protrusions at the L5-S1 causing moderate right and mild left neural foraminal stenosis and mild neural foraminal narrowing due to congenitally short pedicles at the L4-5. His surgical history included 11/13/2014, the injured worker a left sided L5 and S1 foraminotomy and decompression and partial L5 laminotomy. The physical therapy initial evaluation dated 11/14/2014 indicated the injured worker presented with a decline in function status post lumbar surgery. The physical examination revealed range of motion for the bilateral upper and lower extremities within functional limits. There were no strength deficits identified and light touch sensation was within normal limits. The injured worker rated his pain 5/10. His current medications included Norco 10 mg-325 mg 1-2 every 4 hours not to exceed 10 tablets a day and methadone 10 mg 2 every 8 hours not to exceed 6 tablets a day. The plan of care included continued physical therapy. The request was for 1 cold therapy unit; however, the rationale for the request and the Request for Authorization form were not included for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

One (1) 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 (ODG)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Continuous-flow cryotherapy

Decision rationale: The request for 1 cold therapy unit is not medically necessary. The California MTUS/ACOEM Guidelines do not specifically address the use of cold therapy units. The Official Disability Guidelines recommend continuous flow cryotherapy as an option after surgery. Postoperative use generally may be up to 7 days, including home use. The clinical documentation submitted indicated the injured worker underwent surgery on 11/13/2014. Continued use of a continuous flow cryotherapy unit is not supported as it has been more than 7 days past the date of the injured worker's surgery. As such, the request for 1 cold therapy unit is not medically necessary.