

Case Number:	CM14-0031300		
Date Assigned:	05/02/2014	Date of Injury:	12/29/2009
Decision Date:	02/27/2015	UR Denial Date:	01/23/2014
Priority:	Standard	Application Received:	02/03/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California, Hawaii

Certification(s)/Specialty: Physical Medicine & Rehabn

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 (IW) is a 60-year-old male with 12/29/09 date of injury after falling on right buttocks at work. Records indicate that he is status-post left hip replacement on 5/30/12. The attending physician report dated 1/2/14 (138) indicates that the patient is currently ambulatory with cane and has an appointment with a hip replacement surgeon tomorrow. IW feels same as last visit. Left hip pain graded 2/10, right hip 8/10 and 4/10 with medication. Physical exam notes limited and painful hip range of motion. At the time of the 1/2/14 evaluation the IW was not undergoing physical therapy. The current diagnoses are: 1. Status-post left hip arthroscopy (failed) 2. Total left hip arthroplasty 5/30/123. Early osteoarthritis right hip The utilization review report dated 1/23/14 denied the request for purchase of cold therapy unit based on lack of documentation to support medical necessity.

IMR ISSUES, DECISIONS AND RATIONALES

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

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 Official Disability Guidelines (ODG)

Decision rationale: The injured worker has persistent aching pain in both hips. The current request is for purchase of cold therapy unit. The utilization review report indicates there was a request for cold therapy unit on 1/20/14, but I was unable to locate it in the 366 pages of records supplied for review. The nearest attending physician report dated 1/2/14 made no mention of a cold therapy unit. The only discussion was the following medication; Norco, Ambien, and Prilosec. The MTUS guidelines do not address Cold Therapy Unit (CTU). The ODG guidelines state that continuous flow cryotherapy is recommended as an option following surgery for up to 7 days. In this case, the request appears to be for purchase rather than a 7 day rental. The available medical records fail to support the request. As such, recommendation is for denial.