MAXIMUS Federal Services

Case Number:	CM15-0011578		
Date Assigned:	01/29/2015	Date of Injury:	07/30/2013
Decision Date:	03/18/2015	UR Denial Date:	01/02/2015
Priority:	Standard	Application Received:	01/21/2015

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: Illinois, California, Texas
Certification(s)/Specialty: Orthopedic Surgery

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 56 year old male who sustained a work related injury on July 30, 2013, incurring right hip injuries. Treatment included physical therapy and pain medication. Diagnosis included osteoarthritis of the right hip. The injured worker underwent a right total hip replacement on 10/15/14. On January 29, 2015, a request for services of Thermacure Contrast Compression System (30 day rental) and Thermacure Pad were non-certified by Utilization Review noting the Official Disability Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Associated surgical service: Retro Thermacure contrast compression system x 30 days rental, DOS: 10/15/14: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee and Leg

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Hip and Pelvis: Cryotherapy Knee and Leg: Continuous flow cryotherapy; Cold compression therapy

Decision rationale: The California MTUS is silent regarding cold compression units. The Official Disability Guidelines generally support post-operative continuous flow cryotherapy units for up to 7 days, including home use. Guidelines state that there are no published high quality studies on combined cold and compression systems. Given the absence of guideline support for combined units or continuous flow cryotherapy beyond 7 days, this retrospective request for Thermacure contrast compression system x 30 days rental, DOS: 10/15/14, is not medically necessary.

Associated surgical service: Retro Thermacure pad purchase, DOS: 10/15/14: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee and Leg

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.