

Case Number:	CM15-0075706		
Date Assigned:	04/27/2015	Date of Injury:	01/30/2012
Decision Date:	06/19/2015	UR Denial Date:	04/03/2015
Priority:	Standard	Application Received:	04/21/2015

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: New York
 Certification(s)/Specialty: Neurological 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 44 year old male, who sustained an industrial injury on 01/30/2012. On provider visit dated 01/29/2015 the injured worker has reported neck pain and numbness down the left arm and left shoulder pain. On examination of the cervical spine there was decreased sensation over the left C6-C7 dermatome distribution. Left shoulder was noted as having a positive impingement sign on the left. The diagnoses have included C6-C7 stenosis, C6-C7 disc displacement with left foraminal stenosis and left C7 radiculopathy. Treatment to date has included CT scan of the cervical spine, MRI of left shoulder and electromyogram of bilateral upper extremity, injections and medication. Per documentation the injured worker was in need of an urgent C6-C7 anterior cervical discectomy and fusion. The provider requested Postoperative cold therapy unit rental (days), Qty: 30.00, Postoperative physiotherapy Qty: 18.00 and Postoperative pneumatic intermittent compression device, QTY: 1.00

IMR ISSUES, DECISIONS AND RATIONALES

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

Postoperative physiotherapy Qty: 18.00: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Physical Therapy Chapter-postoperative cervical fusion.

Decision rationale: The ODG guidelines do recommend post operative physical therapy. The requested treatment does not indicate the time frame under which the treatment is to follow. The guidelines recommend a principle of fading in frequency. They also recommend the initiation of a home exercise program. The request does not address these issues. The requested treatment: Postoperative physiotherapy Qty: 18.00 is not medically necessary or appropriate.

Postoperative cold therapy unit rental (days), Qty: 30.00: Upheld

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

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

Decision rationale: The ODG guidelines do not recommend continuous flow cryotherapy in the neck. When the ODG guidelines do recommend post-operative continuous cryotherapy it is with the limitation for a week or so time. Even if the ODG guidelines were to recommend post-operative cryotherapy for a patient who underwent cervical surgery, the requested treatment of thirty days exceeds the guidelines. The requested treatment for Postoperative cold therapy unit rental (days), Qty: 30.00: is not medically necessary or appropriate.

Postoperative pneumatic intermittent compression device, QTY: 1.00: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Forearm, Wrist, Hand, Vasopneumatic Device.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee Chapter-lymphedema pump.

Decision rationale: ODG guidelines do recommend lymphedema pumps after a month of conservative therapy including exercise, elevation and use of compression garment. Cervical surgery would not ordinarily limit a patient's ambulation or require immobilization so as to limit exercise. The requested treatment: Postoperative pneumatic intermittent compression device, QTY: 1.00 is not medically necessary or appropriate.