
Independent Medical Review Final Determination Letter

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[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

Dated: 12/30/2013

IMR Case Number:	CM13-0016055	Date of Injury:	05/20/1992
Claims Number:	[REDACTED]	UR Denial Date:	08/06/2013
Priority:	STANDARD	Application Received:	08/25/2013
Employee Name:	[REDACTED]		
Provider Name:	[REDACTED], MD		
Treatment(s) in Dispute Listed on IMR Application:			
THE REQUEST 30 DAY RENTAL CONTRAST COMPRESSION UNIT AND PURCHASE OF A PAD FOR THE UNIT FOR THE RIGHT HIP WAS MEDICALLY CERTIFIED FOR A 7 DAY RENTAL.			

DEAR [REDACTED]

MAXIMUS Federal Services has completed the Independent Medical Review (“IMR”) of the above workers’ compensation case. This letter provides you with the IMR Final Determination and explains how the determination was made.

Final Determination: UPHOLD. This means we decided that none of the disputed items/services are medically necessary and appropriate. A detailed explanation of the decision for each of the disputed items/services is provided later in this letter.

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers’ Compensation. This determination is binding on all parties.

In certain limited circumstances, you can appeal the Final Determination. Appeals must be filed with the Workers’ Compensation Appeals Board within 30 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4610.6(h).

Sincerely,

Paul Manchester, MD, MPH
Medical Director

cc: Department of Industrial Relations, [REDACTED]

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine & Rehabilitation 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 physician 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.

DOCUMENTS REVIEWED

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]

CLINICAL CASE SUMMARY

The physician reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The underlying date of injury in this case is 05/20/1992. The primary treating diagnosis is a lateral meniscus tear. Additionally the patient is status post a sacroiliac joint effusion 05/04/2013. An initial physician reviewer noted that treatment guidelines support a 7-day rental of a contrast compression unit but would not support a 30-day rental. The medical records support the diagnosis of degenerative scoliosis, thoracic radiculitis with a central herniation at T7-T8, and low back and sacroiliac joint pain for which the recently above-mentioned surgery was performed.

IMR DECISION(S) AND RATIONALE(S)

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

1. A 30 day rental of a contrast compression unit is not medically necessary and appropriate.

The Claims Administrator based its decision on the Official Disability Guidelines (ODG), which is not part of the MTUS.

The Physician Reviewer based his/her decision on the Initial Approaches to Treatment (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 3) page 48, which is part of the MTUS and the Official Disability Guidelines (ODG), which is not part of the MTUS.

The Physician Reviewer's decision rationale:

The ACOEM Guidelines, page 48, states, "During the acute to subacute phases for a period of 2 weeks or less, physicians can use passive modalities such as application of heat and cold for temporary amelioration of symptoms and to facilitate mobilization and graded exercise." These guidelines do not encourage the use of thermal modalities beyond such an acute period of time.

There are some situations in which the guidelines may support a period of continuous cold therapy. Among these, Official Disability Guidelines/Treatment of Workers' Compensation/Knee states regarding continuous-flow cryotherapy, "Recommended as an option after surgery...Postoperative use generally may be up to 7 days." These guidelines do not specifically support use of such equipment after sacroiliac surgery. In any event, these guidelines would not support a 30-day rental of such equipment. The medical records do not provide an alternate rationale for this request as an exception to the guidelines. The request for a 30 day rental of a contrast compression unit is not medically necessary and appropriate.

2. A pad purchase for the compression unit is not medically necessary and appropriate.

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

/JR

Disclaimer: MAXIMUS is providing an independent review service under contract with the California Department of Industrial Relations. MAXIMUS is not engaged in the practice of law or medicine. Decisions about the use or nonuse of health care services and treatments are the sole responsibility of the patient and the patient's physician. MAXIMUS is not liable for any consequences arising from these decisions.

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CM13-0016055