MAXIMUS FEDERAL SERVICES, INC.
Independent Medical Review
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MAXIMUS Federal Services

Notice of Independent Medical Review Determination

Dated: **12/14/2013**

Employee:	
Claim Number:	
Date of UR Decision:	12/6/2013
Date of Injury:	12/6/2006
IMR Application Received:	12/10/2013
MAXIMUS Case Number:	CM13-0063469

1) MAXIMUS Federal Services, Inc. has determined the request for **TEC system (iceless cold therapy unit with DVT and lumbar wrap) for 14 days is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 12/10/2013 disputing the Utilization Review Denial dated 12/6/2013. A Notice of Assignment and Request for Information was provided to the above parties on 12/11/2013. A decision has been made for each of the treatment and/or services that were in dispute:

1) MAXIMUS Federal Services, Inc. has determined the request for **TEC system (iceless cold therapy unit with DVT and lumbar wrap) for 14 days is not medically necessary and appropriate.**

Medical Qualifications of the Expert Reviewer:
The independent Medical Doctor who made the decision has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Orthopedic 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 treatments and/or services at issue.

Expert Reviewer Case Summary:
This is a request for a 39 year old male injured back in 2006. The employee was originally diagnosed with sacroliliatis and subsequently underwent surgery for lumbar fusion at L5-S1. He continued to have back pain and was diagnosed with L4-5 disk collapse and segmental instability. He had continued pain despite conservative measures and in 2013 had extension of his fusion to include the L4-5 segment with instrumentation along with L4-5 decompression of stenosis. He reported 5/10 level of continued back pain and a 50% reduction of his leg pain at 2 months postop. 5 months after surgery the patient complained of increased pain in the back and left leg. CT scan documents the bone grafting in L4-5 but shows dislodgement of the screw head from the rod/screw construct on the left side. At issue is request for TEC system (iceless cold therapy unit with DVT and lumbar wrap) for 14 days after lumbar revision surgery.

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

- Application of Independent Medical Review
- Utilization Review Determination
- Medical Treatment Utilization Schedule (MTUS)
- Medical Records from Claims Administrator

1) **Regarding the request for TEC system (iceless cold therapy unit with DVT and lumbar wrap) for 14 days:**

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision
The Claims Administrator based its decision on the ODG, 11th Edition, 2003, Low Back, Hot and Cold Packs, and Knee and Leg, Continuous-flow cryotherapy, which are not part of the MTUS.

The Expert Reviewer found that no section of the MTUS was applicable. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Expert Reviewer based his/her decision onthe Official Disability Guidelines (ODG), Knee and Leg Chapter, Continuous-flow cryotherapy.

Rationale for the Decision:
Since the revision surgery is not medically necessary, then all associated postop measures are also not medically necessary. In addition, the use of a TEC system (iceless cold therapy unit with DVT and lumbar wrap) for the clinical scenario presented is not medically necessary. Continuous cold therapy is recommended postoperatively in the ODG Knee and Leg section for 7 days but is not indicated for the low back. **The request for TEC system (iceless cold therapy unit with DVT and lumbar wrap) for 14 days is not medically necessary and appropriate.**

Effect of the Decision:
The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the final determination of the Administrative Director, Division of Workers' Compensation. With respect to the medical necessity of the treatment in dispute, this determination is binding on all parties.

In accordance with California Labor Code Section 4610.6(h), a determination of the administrative director may be reviewed only if a verified appeal is filed with the appeals board for hearing and served on all interested parties within 30 days of the date of mailing of the determination to the employee or the employer. The determination of the administrative director shall be presumed to be correct and shall be set aside only upon proof by clear and convincing evidence of one or more of the grounds for appeal listed in Labor Code Section 4610.6(h)(1) through (5).

Sincerely,

Paul Manchester, MD, MPH
Medical Director

cc: Department of Industrial Relations
Division of Workers' Compensation
1515 Clay Street, 18th Floor
Oakland, CA 94612

/dj

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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