

Case Number:	CM14-0003318		
Date Assigned:	01/31/2014	Date of Injury:	08/27/2000
Decision Date:	06/20/2014	UR Denial Date:	12/27/2013
Priority:	Standard	Application Received:	01/09/2014

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Pain Management and is licensed to practice in Texas. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 45 year old male who reported a low back injury on 08/27/2000. The mechanism of injury was not provided within the provided medical records. Within the clinical note dated 10/29/2013 the injured worker reported severe lower back pain with pain shooting down the left lower extremity. The physical exam noted muscle guarding and spasms to the buttocks and lumbar spine. The treatment plan included a surgical consult and a prescribed medication list that included Prilosec, Percocet, and Zanaflex. The request for authorization was dated 11/06/2013.

IMR ISSUES, DECISIONS AND RATIONALES

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

GAME READY/COLD UNIT: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Knee and Leg Chapter, Gam Ready Accelerated Recovery System.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg, Continuous-Flow Cryotherapy.

Decision rationale: The request for a Game ready/cold unit is not medically necessary. The Official Disability Guidelines recommended continuous-flow cryotherapy an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage, however, the effect on more frequently treated acute injuries (e.g., muscle strains and contusions) has not been fully evaluated. The injured worker does not have a documented surgery that is within the acute phase of healing and is unclear in the documentation there is an established medical necessity for the request. In addition, the request does not specify the total time the unit would be utilized. Thus, the request is not medically necessary.

TLSO BRACE: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

Decision rationale: The request for the TLSO brace is not medically necessary. According to ACOEM Guidelines, lumbar supports are not recommended after the initial phase of symptoms relief. As the patient was reportedly injured on 08/27/2000, he has exceeded the initial phase of symptoms relief. Thus, the request is not medically necessary.

PREOPERATIVE MEDICAL CLEARANCE WITH [REDACTED]: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back Chapter, Preoperative Testing, General.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Pre-Operative Testing, General.

Decision rationale: The request for preoperative medical clearance with [REDACTED] is not medically necessary. The Official Disability Guidelines state the decision to order preoperative tests should be guided by the patient's clinical history, comorbidities, and physical examination findings. Patients with signs or symptoms of active cardiovascular disease should be evaluated with appropriate testing, regardless of their preoperative status. The injured worker did not have any documented comorbidities that the guidelines would indicate the medical necessity for the request. Thus, the request is not medically necessary.

POST-OP CHIRO; THREE (3) TIMES A WEEK FOR FOUR (4) WEEKS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation Page(s): 58-59.

Decision rationale: The request for post-op chiropractic therapy three (3) times a week for four (4) weeks is not medically necessary. The California MTUS guidelines recommend chiropractic therapy as an option. When appropriate, a trial of 6 visits over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks, is recommended. The request currently does not include a trial period that the guidelines recommend and exceeds the recommended initial trial sessions. Furthermore, it is unclear within the documentation if there is preexisting conditions that would indicate or predict the functional deficits which may benefit from manual therapy the injured worker could sustain post-operatively and is better to ascertain the medical necessity once the surgery is completed. Moreover, the documentation failed to indicate whether the patient will be participating in a therapeutic exercise program to be performed simultaneously with chiropractic care. Thus, the request is not medically necessary.