

Case Number:	CM14-0067582		
Date Assigned:	07/11/2014	Date of Injury:	05/13/2013
Decision Date:	01/16/2015	UR Denial Date:	04/28/2014
Priority:	Standard	Application Received:	05/12/2014

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 licensed in chiropractic, has a subspecialty in medical acupuncture and is licensed to practice in Ohio. 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 68 year-old female, who was injured on May 13, 2013, while performing regular work duties. The mechanism of the injury was due to a trip and fall, resulting in low back pain radiating to both legs, right shoulder pain, right wrist pain, and right knee pain. The injured worker has completed 24 physical therapy sessions, received epidural steroid injections, and knee surgery on May 16, 2014. On June 4, 2014, the injured worker was re-evaluated by pain management for continued complaints of low back pain. The pain management physician discontinued the medication Relafen, continued Ultracet, and prescribed Prilosec for the complaints of heartburn. The records indicate the injured worker is authorized for radiofrequency ablation of the facet joints in the lumbar area, and is awaiting this to be scheduled. The provided records do not demonstrate that the injured worker is in a home based exercise program. The request for authorization is for an ortho follow-up with [REDACTED] for low back surgery, and Chiro follow up 2 x 4. The primary diagnosis is wrist sprain and strain. Additional diagnoses are: lumbar sprain/strain, radicular neuralgia bilateral legs, right shoulder sprain/strain, right wrist sprain/strain, and right knee sprain/strain. On April 28, 2014, Utilization Review non-certified the request for ortho follow up with [REDACTED] for low back surgery due to records indicating that this follow up had been previously authorized on April 2, 2014. Utilization review non-certified the request for chiro follow up 2 x 4 due to the injured worker previously completing 21 visits as of September 2013, documentation of the treatment not provided, and it being unclear why additional conservative treatment was being sought, as surgery was certified for the back, and knee, and initial cortisone injection. In addition, Utilization Review indicates there is no information regarding the injured worker being in an active home exercise program. Utilization Review indicates the determination was based on MTUS chronic pain treatment guidelines. The request for authorization is for an ortho follow-up with [REDACTED] for low

back surgery, and Chiro follow up 2 x 4. The primary diagnosis is wrist sprain and strain. Additional diagnoses are: lumbar sprain/strain, radicular neuralgia bilateral legs, right shoulder sprain/strain, right wrist sprain/strain, and right knee sprain/strain. On April 28, 2014, Utilization Review non-certified the request for ortho follow up with [REDACTED] for low back surgery due to records indicating that this follow up had been previously authorized on April 2, 2014. Utilization review non-certified the request for chiro follow up 2 x 4 due to the injured worker previously completing 21 visits as of September 2013, documentation of the treatment not provided, and it being unclear why additional conservative treatment was being sought, as surgery was certified for the back, and knee, and initial cortisone injection. In addition, Utilization Review indicates there is no information regarding the injured worker being in an active home exercise program. Utilization Review indicates the determination was based on MTUS chronic pain treatment guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Orthopedic follow up with [REDACTED] for Low Back Surgery: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

Decision rationale: The office note dated 7/8/14 from the primary treating physician notes that low back surgery has yet to be performed. There is also no initial evaluation for review from the treating surgeon. In light of this and the fact that the treatment request has previously been approved, the duplicate request is not medically necessary.

Chiropractic Follow Up 2 x 4: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

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

Decision rationale: MTUS chronic pain guidelines recommend a trial of 6 visits over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks. As of September 2013 the claimant has received 21 visits with an undermined number of visits after this date. There is no evidence of functional improvement from previous treatment or a change in work status. Based on the lack of medical evidence and the request exceeding MTUS recommendations the treatment request is deemed not medically necessary.