

Case Number:	CM15-0183294		
Date Assigned:	10/02/2015	Date of Injury:	01/08/2013
Decision Date:	11/13/2015	UR Denial Date:	09/02/2015
Priority:	Standard	Application Received:	09/17/2015

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: Illinois, California, Texas
 Certification(s)/Specialty: Orthopedic 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:

This injured worker is a 47-year-old male who sustained an industrial injury on 1/8/13, relative to a motor vehicle accident. Past medical history was positive for high cholesterol. Past surgical history was positive for anterior cervical discectomy and fusion at C5/6 on 9/5/13. The 4/13/15 lumbar spine MRI revealed degenerative disc disease at L4/5 and L5/S1 with disc bulges. Records documented Toradol IM (intramuscular) injections were provided on 5/4/15 and 6/10/15 for flare-ups of pain. The 8/26/15 treating physician report cited on-going low back pain with increasing bilateral lower extremity pain, numbness and tingling. Physical exam documented positive right straight leg raise, antalgic gait, and lumbar tenderness and muscle spasms. There was weakness and numbness noted on the right in an L5 and S1 distribution. X-rays demonstrated 5 mm of segmental motion at L4/5 and L5/S1. The diagnosis was lumbosacral strain with bulge at L4/5 and L5/S1 with radiculopathy and instability. The injured worker had failed physical therapy, acupuncture, injections, medications, and activity modification. There were no confounding psychological issues. A Toradol IM injection was provided. Authorization was requested for anterior decompression and lumbar fusion at L4/5 and L5/S1 with allograft, cage and plate, shower chair, raised toilet seat, co-surgeon, 3-day inpatient stay, medical clearance, LSO back brace, 12 post-operative physical therapy sessions, a bone growth stimulator, and a muscle stimulator. Associated surgical requests also included a hip kit, IM Toradol injection performed 8/26/15, and a hot/cold therapy unit. The 9/2/15 utilization review certified the requests for anterior decompression and lumbar fusion at L4/5 and L5/S1 with allograft, cage and plate, shower chair, raised toilet seat, co-surgeon, 3-day inpatient stay, medical clearance, LSO back brace, and post-operative physical therapy 12 sessions. The request for a bone growth stimulator was modified to a 3-month rental and a

request for a muscle stimulator was modified to 30-day rental. The request for a hip kit was non-certified as there was no documentation relative to the components of the requested hip kit in which to apply appropriate evidence based guidelines. The request for an IM Toradol injection was non-certified as there was no documentation of an acute exacerbation of pain or that the patient was unable to take oral medications at this time. The request for a hot/cold therapy unit was non-certified as there was no provided rationale for a high-tech device versus that of local at-home applications.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hip kit: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and leg Chapter, Durable Medical Equipment (DME).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Exercise.

Decision rationale: The California MTUS supports the use of exercise for patients in the post-operative period. Exercise programs are reported superior to treatment programs that do not include exercise. Guidelines state that there is no sufficient evidence to support the recommendation of any particular exercise regime over any other exercise regime. Guideline criteria have not been met. There is no compelling reason to support the medical necessity of a pre-packaged generic hip kit over an individualized home exercise program designed by the injured worker's physical therapist. Therefore, this request is not medically necessary.

IM (intramuscular) Toradol: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Ketorolac (Toradol).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, specific drug list & adverse effects. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain: Ketorolac (Toradol®); NSAIDs, specific drug list & adverse effects.

Decision rationale: The California Medical Treatment Utilization Schedule does not recommend Toradol for minor or chronic painful conditions. The Official Disability Guidelines indicate that Toradol administered intramuscularly may be used as an alternative to opioid therapy and generally for moderately severe acute pain. Guideline criteria have not been met. This injured worker presented with chronic low back pain and increased lower extremity radicular symptoms. There was no evidence of acute moderately severe pain. There is no

compelling rationale to support the medical necessity of an IM injection of Toradol on 8/26/15 over oral medications. Therefore, this request is not medically necessary.

Hot/cold therapy unit: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Low Back Chapter, Cold/heat packs.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Physical Methods. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), Occupational Medical Practice Guidelines, Chapter 12 Low Back Disorders (Revised 2007), Hot and cold therapies, page(s) 160-161.

Decision rationale: The California MTUS are silent regarding hot/cold therapy devices, but recommend at home applications of hot or cold packs. The ACOEM Revised Low Back Disorder Guidelines state that the routine use of high-tech devices for hot or cold therapy is not recommended in the treatment of lower back pain. Guidelines support the use of hot or cold packs for patients with low back complaints. Guideline criteria have not been met. There is no compelling reason submitted to support the medical necessity of a hot/cold therapy unit in the absence of guideline support. Therefore, this request is not medically necessary.