MAXIMUS Federal Services

Case Number:	CM13-0064987		
Date Assigned:	01/03/2014	Date of Injury:	03/04/2002
Decision Date:	05/21/2014	UR Denial Date:	11/19/2013
Priority:	Standard	Application Received:	12/12/2013

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 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 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 patient sustained a neck injury on 03/04/02 and ultimately underwent a C3-7 anterior cervical discectomy and fusion performed in June of 2007. The clinical records provided for review included a 10/03/13 follow up report noting complaints of neck pain with radiating bilateral upper extremity complaints of weakness and numbness. Physical examination showed restricted cervical range of motion, a left sided positive Spurling's, and diminished sensation to the mid forearm bilaterally, the left middle digit in a C7 dermatomal distribution and muscle weakness to the interosseous and FDI bilaterally. There was also noted to be diminished grip strength and diminished strength with elbow flexion and extension bilaterally. An imaging report of an MRI dated 08/20/13 showed evidence of prior C3-7 anterior fusion. The report also note extensive artifact with no other supported finding. Based on recent failed conservative care, the Final Determination Letter for IMR Case Number CM13-0064987 3 recommendation was made for surgery for a right sided C5-6 and C6-7 foraminotomy as well as continued medications to include Norco, Soma, Ambien, the purchase of a walker and an Orthostim-4 unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

PRESCRIPTION OF AMBIEN 10MG AT BEDTIME (QUANTITY UNKNOWN): 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 Chaper, Zolpidem

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Procedure - Zolpidem Ambien

Decision rationale: California MTUS and ACOEM Guidelines do not address the use of short acting non Benzodiazepine hypnotics. Based upon the Official Disability Guidelines, the continued use of Ambien would not be recommended. The medical records for review document that the claimant has chronic complaints of neck pain. The Official Disability Guidelines recommend that Ambien should be limited to short term use for two to six weeks for the treatment of insomnia. The chronic use of Ambien cannot be supported. Therefore, the request is not medically necessary.

PRESCRIPTION OF SOMA 350MG, FOUR TIMES A DAY AS NEEDED (QUANTITY UNKNOWN): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol (Soma) Page(s): 63.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol and Weaning of Medications Page(s): 29,124.

Decision rationale: California MTUS Chronic Pain Guidelines also do not support the chronic use of Soma. Chronic Pain Guidelines clearly recommend that Soma is not indicated for long term use due to diminishing effects, adverse side effects and adverse effect profile. Therefore, the request is not medically necessary.

PRESCRIPTION OF NORCO 10/325MG #90: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47-48. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, 2nd Edition (2004) Official Disability Guidelines (ODG), Pain Chapter

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Hydrocodone, Opioids Page(s): 51, 79-80, 91-92.

Decision rationale: California MTUS Chronic Pain Guidelines do not support continued use of Norco. The records indicate that this has ongoing complaints with no documentation of benefit or functional improvement in terms of activities and decrease in subjective pain complaints with the current use of this agent. The Chronic Pain Guidelines state that continued use of short acting narcotic analgesics is not recommended if documentation of significant benefit including advancements of activities is not noted. Continued use of this medication at this chronic stage in claimant's course of care would not be indicated. Therefore, the request is not medically necessary.

ORTHO STIM IV 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), Neck and Upper Back Chapter, Bone Growth Stimulators (BGS)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118, 120-121.

Decision rationale: California MTUS Chronic Pain Guidelines do not support the recommendation for an Orthostim-4 unit. Orthostim-4 is a combination of interferential and neuromuscular electrical stimulation. The Chronic Pain Guidelines document that Neuromuscular electrical stimulation is only recommended as part of a primary rehabilitative process following a stroke. There is currently no indication for its use in the acute or chronic setting of pain. Therefore, the request is not medically necessary.

PURCHASE OF A WALKER: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee Procedure - Walking Aids (Canes, Crutches, Braches, Orthoses & Walkers)

Decision rationale: California MTUS and ACOEM Guidelines do not address the use of a walker. The Official Disability Guidelines do not recommend the use of a walker. The surgical process for the cervical spine has not been supported by clinical records. The use of an ambulatory device in this individual for whom surgery is not being considered would not be supported. Therefore, the request is not medically necessary.

C4-C6 LAMINECTOMY, RIGHT SIDED C5-C6, AND C6-7 FORAMINOTOMY: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 180. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, 2nd Edition (2004)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 166, 179. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, 2nd Edition (2004)

Decision rationale: Based on California ACOEM Guidelines, the proposed C4-C6 laminectomy, right side C5-6 and C6-7 foraminotomy would not be supported. While the claimant is known to have chronic complaints of cervical and upper extremity radicular pain, there is no current clinical correlation between imaging studies and physical examination findings to support the surgical process. This individual is already status post a C3-7 fusion. The report of a recent MRI scan fails to demonstrate specific compressive pathology at the C5-6 and

C6 level to necessitate the procedure. Therefore, the request in this case would not be medically necessary.