

Case Number:	CM13-0070873		
Date Assigned:	01/08/2014	Date of Injury:	11/23/1998
Decision Date:	04/22/2014	UR Denial Date:	12/02/2013
Priority:	Standard	Application Received:	12/26/2013

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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Management, 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:

This is a 55-year-old with an November 23, 1999, industrial injury claim. She has been diagnosed with s/p lumbar spine fusion (L2-S1); lumbago; cervicalgia; and lumbar disc disease with myelopathy. According to the October 18, 2013 spinal orthopedic report from [REDACTED], the patient presents with 8/10 neck pain radiating to the bilateral arms, and 8/10 low back pain with numbness in the right leg. [REDACTED] notes adjacent segment stenosis at L1/2 and L2/3. The plan was for an ESI L2/3, for the cervical spine, recommends fusion C5/6 and C6/7.

IMR ISSUES, DECISIONS AND RATIONALES

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

AN EPIDURAL STEROID INJECTION (ESI) TO L2-3 WITH PAIN MANAGEMENT:
Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46.

Decision rationale: The patient presents with neck and back pain. On exam, [REDACTED] found decreased sensation to light touch and pinprick over the right anterior thigh. September 9, 2013

MRI shows disc protrusion L2/3, hypertrophy of facet joints and encroachment of the left and right L3 transiting nerve roots and foraminal stenosis encroaching the L2 exiting roots bilaterally. L3-S1 is surgically fused. The orthopedic spinal surgeon requests an ESI at L2/3. The request appears to be in accordance with Chronic Pain Medical Treatment Guidelines with physical exam findings of L2 or L3 sensory changes at the anterior thigh and corroboration with MRI findings. The request for an ESI to L2-3 with pain management consultation is medically necessary and appropriate.

ANTERIOR CERVICAL DISCECTOMY AND FUSION (ACDF), C5-6 AND C6-7 WITH PRE-OPERATIVE CLEARANCE: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 180.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 179 - 181.

Decision rationale: The patient presents with neck and back pain. According to [REDACTED], the cervical ROM is full, but there is pain on extension. Sensation to pinprick and light touch are intact in both upper extremities. The right brachioradialis reflex is absent and there is some 4/5 weakness in the right interosseous muscles. Hoffman's was positive on the right, Spurlings positive on the right. There are no MRI's of the cervical spine provided for review. The physician did provide the cervical flexion/extension radiograph report that shows 3-mm retrolisthesis of C5 on C6 in extension suggesting instability, also 2-mm anterolisthesis at C2 on C3 in flexion. The request before me is for ACDF at C5/6 and C6/7. MTUS/ACOEM guidelines state a surgical consultation is indicated with persistent, severe, and disabling shoulder or arm symptoms, activity limitation over a month or with progression of symptoms, clear clinical, imaging and electrophysiologic evidence consistently indicated the same lesion that has been shown to benefit from surgical repair. There are not electrodiagnostic studies provided for this IMR, there are no progressive symptoms and no disabling shoulder or arm symptoms identified on examination. The Neck and Upper Back Complaints Chapter of the ACOEM Practice Guidelines states: "The efficacy of cervical fusion for patients with chronic cervical pain without instability has not been demonstrated." The flex/ext cervical radiographs did suggest instability at C2/3 and C5/6, but not at C6/7. The request as written for fusion including C6/7 without instability is not in accordance with the Neck and Upper Back Complaints Chapter of the ACOEM Practice Guidelines. The request for an ACDF at C5-6 and C6-7 with pre-operative clearance is not medically necessary or appropriate.

POST-OPERATIVE PHYSICAL THERAPY, TWICE PER WEEK FOR SIX WEEKS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99, Postsurgical Treatment Guidelines.

Decision rationale: The patient presents with neck and back pain. The 2-level anterior cervical discectomy and fusion (ACDF) suggested by the physician was not found to be in accordance with ACOEM Practice Guidelines, and was not recommended. I have been asked to review for post-operative physical therapy for twelve sessions for a surgical procedure that was not recommended. If the surgery met Chronic Pain Medical Treatment Guidelines or Post-Surgical Treatment Guidelines criteria and were approved, the request for twelve post-operative physical therapy sessions is in accordance with the Post-Surgical Treatment Guidelines. Since the surgery was not necessary, the "post-operative" physical therapy is not necessary, but for general physical therapy, the Chronic Pain Medical Treatment Guidelines recommends eight to ten sessions for various neuralgias, and the request for twelve visits exceeds this. The request for post-operative physical therapy, twice per week for six weeks, is not medically necessary or appropriate.

A THREE-IN-ONE COMMODORE, SOFT COLLAR BRACE, AND WALKER: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 175.

Decision rationale: The patient presents with neck and back pain. The 2-level cervical ACDF suggested by the physician was not found to be in accordance with MTUS/ACOEM guidelines, and was not recommended. Without the cervical surgery, MTUS/ACOEM states "cervical collars have not been shown to have any lasting benefit, except for comfort in the first few days of the clinical course in severe cases" The patient's injury was in 1999, the need for a cervical collar is not in accordance with ACOEM guidelines. The request for a three-in-one commode, a soft collar brace, and walker, are not medically necessary or appropriate.

HOME HEALTH CARE, TWO HOURS PER DAY FOR TWO WEEKS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 51.

Decision rationale: The patient presents with neck and back pain. The 2-level cervical ACDF suggested by the physician was not found to be in accordance with the ACOEM Practice Guidelines, and was not recommended. There was no rationale provided for the home health care. The patient does not appear to be homebound and there was no description of what medical treatment was needed at home. The Chronic Pain Medical Treatment Guidelines states "Medical treatment does not include homemaker services like shopping, cleaning, and laundry, and personal care given by home health aides like bathing, dressing, and using the bathroom when this is the only care needed" The request is not in accordance with Chronic Pain Medical

Treatment Guidelines. The request for home health care, two hours per day for two weeks, is not medically necessary or appropriate.

TRANSPORTATION TO AND FROM ADL'S AND TREATMENT: 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 Aetna Clinical Policy Bulletin: Home Health Aides; Number: 0218

Decision rationale: There may be some Labor Code or Regulation that allows for transportation to and from medical office visits. But transportation for "ADLs" is vague and does not imply medical treatment. MTUS and ODG do not discuss transportation for non-medical visits. Aetna guidelines were consulted, and Aetna states " A home health aide is a provider who assists a member with non-skilled care to meet activities of daily living, thereby maintaining the individual in his or her home environment. Generally, the following services are considered not medically necessary: Babysitting services, House cleaning, Transportation." The request for transportation to and from ADL's and Treatment is not medically necessary or appropriate.