

Case Number:	CM14-0005038		
Date Assigned:	01/24/2014	Date of Injury:	08/14/2009
Decision Date:	06/09/2014	UR Denial Date:	01/03/2014
Priority:	Standard	Application Received:	01/14/2014

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 Orthopedic Surgeon, 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 46-year-old who reported a work injury on August 14, 2006. The injured worker was seen on November 5, 2013 for reported neck pain that she rated 9/10 with reported swelling up into the left side of the face and neck. The physical examination of the cervical spine found decreased range of motion of approximately 50%. The Spurling's test was positive on the left side. The MRI findings include a 2 mm left foraminal disc herniation with severe neural foraminal stenosis on the left side. She was diagnosed with herniated nucleus pulposus at C5-C6 with left upper extremity radiculopathy consistent with severe neural foraminal stenosis. The treatment plan recommends an anterior cervical decompression and fusion at C5-C6 to decompress the left C5-C6 foramina and remove the disc herniation. The State of California Division of Workers Compensation Request for Authorization for Medical Treatment dated November 5, 2013 was submitted with this review.

IMR ISSUES, DECISIONS AND RATIONALES

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

PRE-OPERATIVE INTERNAL MEDICINE CLEARANCE: 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 Lumbar And Thoracic (Acute And Chronic) Chapters.

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-Lumbar & Thoracic, Preoperative Testing, General.

Decision rationale: The Official Disability Guidelines recommend preoperative testing for the purpose of determining fitness for anesthesia and identifying patients at high risk of postoperative complications may be to conduct a history and physical examination, with selective testing based on the clinician's findings. However, the relative effect on patient and surgical outcomes, as well as resource utilization, of these two approaches is unknown. The latest AHRQ comparative effectiveness research on the benefits and harms of routine preoperative testing, concludes that, except for cataract surgery, there is insufficient evidence comparing routine and per-protocol testing. There is a lack of documentation of co-morbidities to support the need for pre-operative clearance. The request for pre-operative internal medicine clearance is not medically necessary or appropriate.

CERVICAL BRACE: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Neck & Upper Back Chapter, Cervical Collar, Post Operative.

Decision rationale: The Official Disability Guidelines do not recommended a brace after cervical fusion. The use of a cervical brace does not improve the fusion rate or the clinical outcomes of patients undergoing single-level anterior cervical fusion with plating. The request for a cervical brace is not medically necessary or appropriate.

AGGRESSIVE POSTOPERATIVE PHYSICAL THERAPY TREATMENT AND REHABILITATION PROGRAM TO THE CERVICAL SPINE, TOTALING 36 VISITS:
Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 10-11.

Decision rationale: The Post-Surgical Treatment Guidelines recommend an initial course of therapy. This is one half of the number of visits specified in the general course of therapy for the specific surgery in the postsurgical physical medicine treatment recommendations. Postsurgical treatment (fusion, after graft maturity): 24 visits over 16 weeks. Postsurgical physical medicine treatment period: six months. The number of visits requested exceeds the recommended visits recommended by the guidelines. The request for aggressive postoperative physical therapy treatment and rehabilitation program to the cervical spine, totaling 36 visits, is not medically necessary or appropriate.

TRANSPORTATION TO AND FROM FACILITY: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Department Of Health Care Services-California, Criteria for Medical Transportation.

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

Decision rationale: The Official Disability Guidelines recommend transportation for medically-necessary appointments in the same community for patients with disabilities preventing them from self-transport. The documents provided do not adequately support the injured workers need for transportation. The request for transportation to and from the facility is not medically necessary or appropriate.

MEDROX PATCHES APPLY ONE PATCH TO THE AFFECTED AREA 1-2 TIMES A DAY, #30: 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 Topical Analgesics Section Page(s): 111-112.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state this medication containing capsaicin is largely experimental in use. There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The use of these compounded agents requires knowledge of the specific analgesic effect of each agent and how it will be useful for the specific therapeutic goal required. Medrox contains methyl salicylate 5%, menthol 5% and capsaicin 0.0375%.⁵ The Chronic Pain Medical Treatment Guidelines state there have been no studies of a 0.0375% formulation of capsaicin and there is no current indication that this increase over a 0.025% formulation would provide any further efficacy. The medication contains a formulation of capsaicin which exceed guideline recommendations. As one component of the medication is not recommended, the entire medication is not recommended per guidelines. The request for Medrox patches, one patch applied to the affected area one to two times daily, thirty count, is not medically necessary or appropriate.