

Case Number:	CM14-0009173		
Date Assigned:	02/14/2014	Date of Injury:	04/24/2001
Decision Date:	08/08/2014	UR Denial Date:	01/15/2014
Priority:	Standard	Application Received:	01/23/2014

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 Neurological 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 records presented for review indicate that this 41-year-old female was reportedly injured on April 24, 2001. The mechanism of injury is noted as lifting a patient onto a gurney. The most recent progress note, dated March 27, 2014, indicates that there are ongoing complaints of pain and spasms following cervical spine surgery. Current medications include Lidoderm patches, OxyContin, Percocet, tramadol, Amitiza, Skelaxin, and Zanaflex. No specific physical examination was performed on this date. Previous treatment includes cervical spine fusion on March 16, 2014. Weaning of postoperative medications was anticipated and refills were provided for OxyContin, Percocet, and Zanaflex. A request was made for a cervical spine discectomy and fusion, an assistant surgeon, a two day hospital inpatient stay, preoperative medical clearance, a chest x-ray, a heart cervical collar, a soft cervical collar, a bone growth stimulator, a pneumatic intermittent compression device, post-op physical therapy, and a 30 day rental of a cold therapy unit and was not certified in the pre-authorization process on January 14, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

BONE GROWTH STIMULATOR: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Postsurgical Treatment Guidelines Page(s): Therapy. Decision based on Non-MTUS Citation Official Disability Guidelines, Cervical Spine.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back (Acute & Chronic), Bone growth stimulator, Updated May 30, 2014.

Decision rationale: According to the utilization management review dated January 14, 2014, a previous request for an anterior cervical discectomy and fusion at C4-C5 and C5-C6 was stated that to be medically necessary. A previous MRI of the cervical spine does not show any thecal sac or nerve root compression. Prior nerve conduction studies were unavailable. Without specific corroboration of the injured employee symptoms, physical examination findings, and objective studies showing radicular symptoms and neuropathic findings a request for a cervical spine discectomy and fusion is not medically necessary. Therefore this request for the use of a bone growth stimulator is not medically necessary.

PNEUMATIC INTERMITTENT COMPRESSION DEVICE: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Postsurgical Treatment Guidelines Page(s): Therapy. Decision based on Non-MTUS Citation Official Disability Guidelines, Cervical Spine.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee and leg, Venous thrombosis, Updated June 5, 2014.

Decision rationale: According to the utilization management review dated January 14, 2014, a previous request for an anterior cervical discectomy and fusion at C4-C5 and C5-C6 was stated to be medically necessary. A previous MRI of the cervical spine does not show any thecal sac or nerve root compression. Prior nerve conduction studies were unavailable. Without specific corroboration of the injured employee symptoms, physical examination findings, and objective studies showing radicular symptoms and neuropathic findings a request for a cervical spine discectomy and fusion is not medically necessary. Therefore this request for the use of a pneumatic intermittent compression device is not medically necessary.

POST-OP PHYSICAL THERAPY 3 TIMES A WEEK FOR 6 WEEKS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Postsurgical Treatment Guidelines Page(s): Therapy. Decision based on Non-MTUS Citation Official Disability Guidelines, Cervical Spine.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back (Acute & Chronic), Physical therapy, Updated May, 2014.

Decision rationale: According to the utilization management review dated January 14, 2014, a previous request for an anterior cervical discectomy and fusion at C4-C5 and C5-C6 was stated to be medically necessary. A previous MRI of the cervical spine does not show any thecal sac or nerve root compression. Prior nerve conduction studies were unavailable. Without specific

corroboration of the injured employee symptoms, physical examination findings, and objective studies showing radicular symptoms and neuropathic findings a request for a cervical spine discectomy and fusion is not medically necessary. Therefore this request for postoperative physical therapy is not medically necessary.

COLD THERAPY 30 DAY RENTAL: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Postsurgical Treatment Guidelines Page(s): Therapy. Decision based on Non-MTUS Citation Official Disability Guidelines, Cervical Spine.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee and leg, Continuous flow cryotherapy, Updated June 5, 2014.

Decision rationale: According to the utilization management review dated January 14, 2014, a previous request for an anterior cervical discectomy and fusion at C4-C5 and C5-C6 was stated that to be medically necessary. A previous MRI of the cervical spine does not show any thecal sac or nerve root compression. Prior nerve conduction studies were unavailable. Without specific corroboration of the injured employee symptoms, physical examination findings and objective studies showing radicular symptoms and neuropathic findings a request for a cervical spine discectomy and fusion is not medically necessary. Therefore this request for the use of a cold therapy unit is not medically necessary.