MAXIMUS Federal Services

Case Number:	CM14-0110601		
Date Assigned:	08/13/2014	Date of Injury:	01/26/2012
Decision Date:	09/18/2014	UR Denial Date:	07/09/2014
Priority:	Standard	Application Received:	07/16/2014

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 Spine Surgery 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 48-year-old male who reported injury on 01/26/2012. The mechanism of injury and diagnostic studies were not provided. The surgical history included a lumbar fusion in 07/2013. The injured worker's medication history included Fluriflex and TG Ice which includes Tramadol, Gabapentin, menthol and camphor, as of at least 12/2013. Prior therapies included physical therapy and aquatic therapy. The documentation of 05/23/2014 revealed the injured worker had complaints of neck and low back pain. The injured worker indicated his pain ranged between 6/10 and 7/10 upon waking in the morning. The injured worker was noted to be utilizing transdermal creams which were helping. The physical examination of 02/03/2014 revealed an appeal for medications. The documentation indicated the injured worker had constant cervical pain and lumbar spine pain with bilateral upper extremity pain that was sharp and stabbing. There was noted to be a request for continuing aquatic therapy, and this was noted to be the appeal for the aquatic therapy. The documentation of 06/16/2014 revealed the injured worker had complaints regarding his neck and low back. The injured worker indicated the low back pain was feeling much better. The neck pain was significant. The injured worker indicated the neck pain was 7/10 to 8/10 with constant numbness and tingling with radiation to the upper extremities. The physical examination revealed the injured worker had tenderness at the occipital insertion of the paracervical musculature. There was mild tenderness bilaterally in the trapezii. The midline base of the cervical spine was tender. The neurologic testing was noted to be intact. The injured worker was noted to have decreased range of motion of the cervical spine. There was scapular retraction that was limited and produced rhomboid pain. Full shoulder motion was accompanied by trapezius tenderness and pain. There was no evidence of instability. The reflexes were diminished. The sensation was noted to be diminished in all upper extremities. Strength testing revealed mild inhibition by neck pain with gross weakness. The

injured worker had a mildly positive head compression sign and a normal Spurling's maneuver. The diagnoses included C5-6 disc herniation with bilateral radiculopathy, status post L4-5, L5-S1 lumbar fusion 07/27/2013. The treatment plan included a previously requested surgical intervention for an anterior cervical discectomy and fusion at C5-6, C6-7 and C7-T1 was being waited on for approval. Additionally, the treatment plan included a urinalysis. There was no Request for Authorization submitted to support the requested surgical intervention and ancillary services. However there was a Request for Authorization for the medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

C5-C6, C6-C7 and C7-T1 anterior cervical discectomy and fusion with allograft and instrumentation: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 179-181. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck & Upper Back Chapter, Fusion, anterior cervical.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 179-181. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck & Upper Back Chapter, Fusion, anterior cervical.

Decision rationale: ACOEM Guidelines indicate that a surgical consultation may be appropriate for injured workers who have persistent severe and disabling shoulder and arm symptoms, activity limitations for more than one month or with an extreme progression of symptoms. There should be documentation of clear clinical, imaging and electrophysiologic evidence consistently indicating the same lesion that has been shown to benefit from surgical repair in both the short and long term. There should be documentation of unresolved radicular symptoms after receiving conservative treatment. The clinical documentation submitted for review failed to indicate the injured worker had documentation of activity limitation for more than 1 month, clear clinical imaging and electrophysiological evidence, and unresolved radicular symptoms after receiving conservative treatment. There was no EMG/NCV or MRI submitted for review. The discectomy would not be supported. The Official Disability Guidelines indicates that cervical fusions are recommended as an option in combination with an anterior cervical discectomy for approved indications. The discectomy was not approved and as such, the fusion would not be supported. The original date of request was not provided per the submitted documentation. There was no Request for Authorization submitted for review. Given the above, the request for a C5-C6, C6-C7 and C7-T1 anterior cervical discectomy and fusion with allograft and instrumentation is not medically necessary.

Cervical collar-[redacted]: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Bone stimulator: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Hospital stay; 2 days: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Postoperative evaluation by a RN: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Duracef postoperative: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Zofran postoperative: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Norco postoperative: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Home help: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Postop Sprix spray 15.75mg, 40 units five bottles q6-8 hours or UD: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Postop follow up: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Postoperative physical therapy; eight sessions (2x4), cervical spine: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

FluriFlex cream 240gm cream; apply a thin layer to the affected area twice daily: 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 Flurbiprofen,Topical analgesics ;Cyclobenzaprine Page(s): 72;111;41.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.