

<b>Case Number:</b>	CM14-0054300		
<b>Date Assigned:</b>	08/08/2014	<b>Date of Injury:</b>	02/09/2013
<b>Decision Date:</b>	09/26/2014	<b>UR Denial Date:</b>	03/28/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/23/2014

### 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 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 claimant is a 56-year-old gentleman who was injured in a work related accident on February 9, 2013. Records indicate an injury to the neck. A recent physical examination finding for review of March 19, 2014 described continued complaints of neck pain with radiating pain to the shoulder. Physical examination showed restricted range of motion in nearly all planes with tenderness to palpation, 4/5 motor strength with wrist extension, equal and symmetrical reflexes and no sensory deficit. Reviewed on that date was plain film radiographs which showed degenerative changes from C5 through 7 as well as a prior MRI scan of the cervical spine from June 26, 2013 showing C5-6 posterior disc bulge with osteophyte complex resulting in left greater than right foraminal narrowing and a C6-7 2 millimeter disc bulge with mild bilateral facet joint change and foraminal narrowing. Based on failed conservative care to the cervical spine, a two level anterior cervical discectomy and fusion was recommended at the C5 through 7 level for this individual.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**ANTERIOR CERVICAL DISCECTOMY & FUSION- C5-C6, C6-C7:** 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): 165.

**Decision rationale:** Based on California ACOEM Guidelines, two level fusion would not be supported. The records at present would not indicate the acute need of operative fusion for the diagnosis of degenerative disc disease alone. The California Guidelines typically do not recommend the role of fusion without documentation of chronic cervical pain without instability. When looking at the claimant's clinical assessment, there is no clinical correlation between compressive findings on imaging and the claimant's current physical examination findings. The acute role of a two level anterior cervical discectomy and fusion would not be supported. The request for Anterior Cervical Discectomy & Fusion is not medically necessary.

**1 DAY IN PATIENT HOSPITAL STAY:** 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)-- Official Disability Guidelines Treatment in Worker's Comp, 18th Edition, 2013: neck procedure - Fusion, anterior cervicalFor hospital LOS after admission criteria are met, see Hospital length of stay (LOS).Cervical Fusion, Anterior (81.02 -- Other cervical fusion, anterior technique)Actual data - - median 1 day; mean 2.2 days ( $\hat{A}\pm 0.1$ ); discharges 161,761; charges (mean) \$50,653Best practice target (no complications) -- 1 days.

**Decision rationale:** California MTUS Guidelines are silent. Official Disability Guidelines would not support a one day inpatient stay at the need for operative intervention has not been established. Therefore, request for 1 Day In Patient Hospital Stay is not medically necessary.

**POST OPERATIVE DURABLE MEDICAL EQUIPMENT (DME) HARD CERVICAL COLLAR:** 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): 173-175.

**Decision rationale:** California ACOEM Guidelines would not support postoperative use of a collar as the role of operative intervention has not been established. Therefore, request for Post Operative Durable Medical Equipment (DME) Hard Cervical Collar is not medically necessary.

**POST OPERATIVE DURABLE MEDICAL EQUIPMENT (DME) SOFT CERVICAL COLLAR:** 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): 173-175.

**Decision rationale:** California ACOEM Guidelines would not support postoperative use of a collar as the role of operative intervention has not been established. Therefore, request for Post Operative Durable Medical Equipment (DME) Soft Cervical Collar is not medically necessary.

**POST OPERATIVE DURABLE MEDICAL EQUIPMENT (DME) BONE GROWTH STIMULATOR: 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)-- Official Disability Guidelines Treatment in Worker's Comp , 18th Edition, 2013 Updates: low back procedure - Bone growth stimulators (BGS) Under study. There is conflicting evidence, so case by case recommendations are necessary (some RCTs with efficacy for high risk cases). Some limited evidence exists for improving the fusion rate of spinal fusion surgery in high risk cases (e.g., revision pseudoarthrosis, instability, smoker). (Mooney, 1990) (Marks, 2000) (Akai, 2002) (Simmons, 2004) There is no consistent medical evidence to support or refute use of these devices for improving patient outcomes; there may be a beneficial effect on fusion rates in patients at "high risk", but this has not been convincingly demonstrated. (Resnick, 2005) Also see Fusion for limited number of indications for spinal fusion surgery. See Knee & Leg Chapter for more information on use of Bone-growth stimulators for long bone fractures, where they are recommended for certain conditions. Criteria for use for invasive or non-invasive electrical bone growth stimulators: Either invasive or noninvasive methods of electrical bone growth stimulation may be considered medically necessary as an adjunct to spinal fusion surgery for patients with any of the following risk factors for failed fusion: (1) One or more previous failed spinal fusion(s) (2) Grade III or worse spondylolisthesis (3) Fusion to be performed at more than one level (4) Current smoking habit (Note: Other tobacco use such as chewing tobacco is not considered a risk factor) (5) Diabetes, Renal disease, Alcoholism (6) Significant osteoporosis which has been demonstrated on radiographs. (Kucharzyk, 1999) (Rogozinski, 1996) (Hodges, 2003).

**Decision rationale:** MTUS Guidelines are silent. Official Disability Guidelines would not support the postoperative use of a bone growth stimulator as the need for operative intervention has not been established. Therefore, request for Post Operative Durable Medical Equipment (DME) Bone Growth Stimulator is not medically necessary.

**POST OPERATIVE DURABLE MEDICAL EQUIPMENT (DME) PNEUMATIC INTERMITTENT COMPRESSION DEVICE: 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 Guidelines Official Disability Guidelines (ODG)-- Official Disability Guidelines Treatment in Worker's Comp , 18th Edition, 2013 Updates: forearm/wrist/hand procedure - Vasopneumatic devices Recommended as an option to reduce edema after acute injury. Vasopneumatic devices apply pressure by special equipment to reduce swelling. They may be considered necessary to reduce edema after acute injury. Education for use of lymphedema pump in the home usually requires 1 or 2 sessions. Further treatment of lymphedema by the provider after the educational visits is generally not considered medically necessary. The treatment goal of vasopneumatic devices, such as intermittent compression therapy, is to reduce venous hypertension and edema by assisting venous blood flow back toward the heart. (McCulloch, 1995) (Moseley, 2007) See also Lymphedema pumps.

**Decision rationale:** CA MTUS Guidelines are silent. Official Disability Guidelines would not support a vasopneumatic device for compression as the need of operative intervention has not been established. Therefore, request for Post Operative Durable Medical Equipment (DME) Pneumatic Intermittent Compression Device is not medically necessary.

**PRE-OPERATIVE MEDICAL CLEARANCE:** 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 ACOEM OMPG (Second Edition, 2004), Chapter 7 Independent Medical Examinations and Consultations, page 127 The occupational health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. A referral may be for consultation to aid in the diagnosis, prognosis, therapeutic management, determination of medical stability, and permanent residual loss and/or the examinee's fitness for return to work. A consultant is usually asked to act in an advisory capacity but may sometimes take full responsibility for investigation and/or treatment of an examinee or patient.

**Decision rationale:** California ACOEM Guidelines would not support preoperative testing and assessment as the need for operative intervention has not been established. Therefore, request for Pre-Operative Medical Clearance is not medically necessary.

**PRE-OPERATIVE CHEST X RAY:** 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 ACOEM OMPG (Second Edition, 2004), Chapter 7 Independent Medical Examinations and Consultations, page 127 Introduction The occupational health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. An independent medical assessment also may be useful in avoiding potential conflict(s) of interest when analyzing causation or when prognosis, degree of impairment, or work capacity requires clarification. When a physician is responsible for performing an isolated assessment of an examinee's health or disability for an employer, business, or insurer, a limited examinee-physician relationship should be considered to exist. A referral may be for: -Independent Medical Examination (IME): To provide medicolegal documentation of fact, analysis, and well-reasoned opinion, sometimes including analysis of causality. An IME differs from consultation in that there is no doctor-patient relationship established and medical care is not provided. It may be a means of medical clarification or adjudication in which the physician draws conclusions regarding diagnosis, clinical status, causation, work-relatedness, testing and treatment efficacy and requirements, physical capacities, impairment, and prognosis based on available information. The evaluations must be independent, impartial, and without bias. The client often may be the employer, insurer, state authority, or attorney. Citation(s): Harris J, Occupational Medicine Practice Guidelines, 2nd Edition (2004) - pp. 127 Hegmann K, Occupational Medicine Practice Guidelines, 2nd Ed (2008 Revision) - pp. 503 -Consultation: To aid in the diagnosis, prognosis, therapeutic management, determination of medical stability, and permanent residual loss and/or the examinee's fitness for return to work. A consultant is usually asked to act in an advisory capacity, but may sometimes take full responsibility for investigation and/or treatment of an examinee or patient.

**Decision rationale:** California ACOEM Guidelines would not support preoperative testing and assessment as the need for operative intervention has not been established. The request for Pre-Operative Chest X Ray is not medically necessary.

**NORCO 10/325MG #120:** 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 -- California Medical Treatment Utilization Schedule (MTUS), 2009, Chronic pain, page 76-80, Opioids-Criteria For Use. Therapeutic Trial of Opioids 1) Establish a Treatment Plan. The use of opioids should be part of a treatment plan that is tailored to the patient. Questions to ask prior to starting therapy: (a) Are there reasonable alternatives to treatment, and have these been tried? (b) Is the patient likely to improve? Examples: Was there improvement on opioid treatment in the acute and subacute phases? Were there trials of other treatment, including non-opioid medications? (c) Is there likelihood of abuse or an adverse outcome? See Substance abuse (tolerance, dependence, addiction). (d) Ask about Red Flags indicating that opioids may not be helpful in the chronic phase: (1) Little or no relief with opioid therapy in the acute and subacute phases. (2) The patient has had a psychological evaluation and has been given a diagnosis of somatoform disorder. (3) The patient has been given a diagnosis in one of the particular

diagnostic categories that have not been shown to have good success with opioid therapy: conversion disorder; somatization disorder; pain disorder associated with psychological factors (such as anxiety or depression).(e) When the patient is requesting opioid medications for their pain and inconsistencies are identified in the history, presentation, behaviors or physical findings, physicians and surgeons who make a clinical decision to withhold opioid medications should document the basis for their decision.2) Steps to Take Before a Therapeutic Trial of Opioids: (a) Attempt to determine if the pain is nociceptive or neuropathic. Also attempt to determine if there are underlying contributing psychological issues. Neuropathic pain may require higher doses of opioids, and opioids are not generally recommended as a first-line therapy for some neuropathic pain. (b) A therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics.(c) Before initiating therapy, the patient should set goals, and the continued use of opioids should be contingent on meeting these goals. (d) Baseline pain and functional assessments should be made. Function should include social, physical, psychological, daily and work activities, and should be performed using a validated instrument or numerical rating scale. See Function Measures.(e) Pain related assessment should include history of pain treatment and effect of pain and function. (f) Assess the likelihood that the patient could be weaned from opioids if there is no improvement in pain and function.(g) The patient should have at least one physical and psychosocial assessment by the treating doctor (and a possible second opinion by a specialist) to assess whether a trial of opioids should occur. When subjective complaints do not correlate with imaging studies and/or physical finding Page(s): 76-80.

**Decision rationale:** CA MTUS Guidelines would not support the postoperative use of analgesics as the role of operative intervention has not been established. The request for Norco 10/325mg #120 is not medically necessary.

**POST OPERATIVE PHYSICAL THERAPY- 3 TIMES A WEEK FOR 6 WEEKS-  
CERVICAL SPINE:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

**Decision rationale:** CA MTUS Postsurgical Rehabilitative Guidelines would not support postoperative physical therapy as the need for operative intervention has not been established. The request for Post Operative Physical Therapy- 3 Times A Week For 6 Weeks- Cervical Spine is not medically necessary.