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| Case Number: | CM14-0058187 | | |
| Date Assigned: | 07/09/2014 | Date of Injury: | 10/19/2000 |
| Decision Date: | 08/26/2014 | UR Denial Date: | 04/14/2014 |
| Priority: | Standard | Application Received: | 04/28/2014 |

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, has a subspecialty in Spine 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 injured worker is a 46-year-old male who reported an injury on 10/19/2000. The mechanism of injury involved a fall from a 2-story building. Current diagnoses include postlaminectomy syndrome and cervicgia. The injured worker was evaluated on 11/04/2013. It is noted that the injured worker underwent an anterior cervical fusion at C6-7 with partial corpectomy and hardware placement on 01/05/2012. Previous conservative treatment includes medication management. The injured worker presented with complaints of constant pain in the cervical spine aggravated by repetitive motions, and associated with tingling and numbness in the upper extremities. The current medication regimen includes OxyContin and temazepam. Physical examination on that date revealed paravertebral muscle spasm, significant pain in the cervical spine, tenderness in the levator scapulae, radicular pain component in the upper extremities involving the lateral forearm and consistent with the C5 through C7 nerve roots, dysesthesia at C5 through C7, and suboccipital pain with headaches and cervicgia. The injured worker was given an intramuscular injection of Toradol, Marcaine, and vitamin B12. Treatment recommendations at that time included C6-7 removal of hardware with inspection of fusion and anterior cervical discectomy at C5-6. It is noted that the injured worker underwent x-rays of the cervical spine on 01/18/2012, which indicated anterior fusion at C6-7 with spondylosis at C5-6 and mild levoscoliosis. The injured worker also underwent a CT scan of the cervical spine on 11/05/2012, which indicated anterior fusion at C6-7 with mild disc bulging at C3 through C5 causing significant spinal canal stenosis.

IMR ISSUES, DECISIONS AND RATIONALES

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

C6-7 Removal of hardware and inception at fusion repair pseudoarthrosis.: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) -TWC Neck and Upper Back Procedure Summary last updated 3/7/14.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 179-180. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Hardware implant removal (fixation).

Decision rationale: The California MTUS/ACOEM Practice Guidelines state a referral for surgical consultation is indicated for patients who have persistent, severe, disabling shoulder or arms symptoms; activity limitation for more than 1 month; clear clinical, imaging, and electrophysiologic evidence of a lesion; and unresolved radicular symptoms after receiving conservative treatment. The Official Disability Guidelines do not recommend hardware implant removal except in the case of broken hardware or persistent pain after ruling out other causes of pain such as infection and nonunion. There were no recent imaging studies provided for this review. There is no evidence of broken hardware or an exclusion of other causes such as infection or nonunion. Therefore, the injured worker does not meet criteria for the requested service. As such, the request is not medically necessary and appropriate.

Anterior Cervical discectomy at C5-6 implantation of dynamic hardware, possible junction level C4-5: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) -TWC Neck and Upper Back Procedure Summary last updated 3/7/14.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 179-180. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck & Upper Back Chapter, Discectomy.

Decision rationale: The California MTUS/ACOEM Practice Guidelines state a referral for surgical consultation is indicate for patients who have persistent, severe, disabling shoulder or arms symptoms; activity limitation for more than 1 month; clear clinical, imaging, and electrophysiologic evidence of a lesion; and unresolved radicular symptoms after receiving conservative treatment. The Official Disability Guidelines state a discectomy is indicated when there is evidence of radicular pain and sensory symptoms that correlate with the involved cervical level. There should be evidence of motor deficit or reflex changes, or a positive EMG study. There must also be evidence that the injured worker has received and failed at least a 6 to 8-week trial of conservative care. As per the documentation submitted, there is no evidence of an exhaustion of recent conservative treatment prior to the request for an additional cervical spine surgery. There were no recent imaging studies or electrodiagnostic reports submitted for this review. Based on the clinical information received and the above mentioned guidelines, the request is non-medically necessary and appropriate.

Terocin Patch: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

Decision rationale: The California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is no documentation of a failure to respond to first-line oral medication prior to the initiation of a topical analgesic. There is also no strength, frequency, or quantity listed in the current request. As such, the request is not medically necessary and appropriate.