

Case Number:	CM14-0060760		
Date Assigned:	07/09/2014	Date of Injury:	10/01/2009
Decision Date:	08/22/2014	UR Denial Date:	04/22/2014
Priority:	Standard	Application Received:	05/01/2014

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 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 55-year-old male who reported an injury on 10/01/2009. The mechanism of injury was not provided for review. The injured worker was evaluated on 03/11/2014. It was documented that the injured worker had undergone a CT scan that documented mild to moderate facet arthrosis on the right side at the C2 through C3 and C3 through C4. There were no physical findings included at this clinical examination. The injured worker was evaluated on 04/15/2014. It was noted that the injured worker had 5/5 manual muscle strength with tenderness to palpation of the lumbar and cervical spine. Deep tendon reflexes were noted to be equal bilaterally and the injured worker had intact sensory examination. It was documented that the injured worker had noticeable tremors. A surgical request and medication refill was submitted on 04/15/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Anterior/Posterior Cervical Fusion: 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), Neck and Upper Back (updated 4/14/14), Fusion, Anterior Cervical.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 179-180.

Decision rationale: The requested anterior/posterior cervical fusion is not medically necessary or appropriate. The clinical documentation submitted for review did not provide any consistent symptoms of severe disabling radiculopathy to support the need for surgical intervention. Additionally, California Medical Treatment Utilization Schedule does not support the use of cervical fusion surgery in the absence of significant instability. There were no independent reports of imaging to support the need for the requested surgery. The clinical documentation submitted for review does not provide any evidence of instability to support the need for a fusion. Furthermore, the request as it is submitted does not appropriately identify the requested levels for treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested anterior/posterior cervical fusion is not medically necessary or appropriate.

Anaprox DS 550 mg #100: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, specific drug list & adverse effects; NSAIDs, gastrointestinal symptoms and cardiovascular risk Page(s): 73; 68-69.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic pain and NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 67 and 60.

Decision rationale: The requested Anaprox DS 550 mg twice a day #100 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does support the use of this medication as a first line medication in the management of chronic pain. However, the California Medical Treatment Utilization Schedule recommends ongoing use of medications in the management of chronic pain is supported by documented functional benefit and evidence of pain relief. The clinical documentation submitted for review does not provide any evidence of significant functional benefit or pain relief resulting from medication usage. As such, the requested Anaprox DS 550 mg #100 is not medically necessary and appropriate.

Omeprazole 20 mg #50:

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, specific drug list & adverse effects; NSAIDs, gastrointestinal symptoms and cardiovascular risk Page(s): 73; 68-69.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68.

Decision rationale: The requested Omeprazole 20 mg #50 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends the ongoing use of gastrointestinal protectants be supported by an evaluation of the injured worker's gastrointestinal system to support that they are at risk for developing issues related to medication usage. The clinical documentation submitted for review does not provide an adequate assessment of the injured worker's gastrointestinal system to support that they are at continued risk for developing

gastrointestinal symptoms related to ongoing medication usage. Furthermore, the request as it is submitted does not adequately identify a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Omeprazole 20 mg #50 is not medically necessary or appropriate.