MAXIMUS Federal Services

Case Number:	CM15-0107874		
Date Assigned:	06/12/2015	Date of Injury:	12/15/1992
Decision Date:	08/18/2015	UR Denial Date:	05/13/2015
Priority:	Standard	Application Received:	06/03/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: New York
Certification(s)/Specialty: Neurological Surgery

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 72 year old female, who sustained an industrial injury on 12/15/1992. Initial complaints and diagnosis were not clearly documented. On provider visit dated 05/05/2015 the injured worker has reported neck pain which radiates down the right upper extremity's to the hand and intermittently the finger, rated as 8/10 without medication and 7/10 with medication and low back pain that radiates down the left lower extremity rated as an 8/10 without medication and a 7/10 with medication. On examination of the tenderness was note over the right more than left trapezius musculature. The diagnoses have included status post partial corpectomy at C5, ACDF C4-C6 on 12/2014 and C5 compression fracture with segmentation kyphosis. Treatment to date has included Dilaudid, Opana ER and Xanax. The provider recommended the removal of hardware C1-C7, with instrumentation and fusion anterior and posteriorly from C3-C6. The provider requested outpatient medical pre-operative medical clearance, laboratory studies, electromyogram and chest x-ray, cold therapy unit 30 day rental, pneumatic intermittent compression device, ongoing home health care 12 hours a day, Dilaudid and Xanax.

IMR ISSUES, DECISIONS AND RATIONALES

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

Outpatient medical pre-operative medical clearance and labs including CBC, BMP, UA, PT/PTT, EKG, and CXR: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Preoperative testing.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Physicial Therapy Chapter-Pre-operative testing, general.

Decision rationale: The ODG guidelines recommend investigation and testing when the information obtained will effect post-operative management and decision making. Documentation does not contain evidence of a bleeding disorder or anemia or medications the patient is taking to substantiate obtaining a coagulation panel or blood count. Documentation does not point to concerns for which a BMP would be obtained. While six months earlier the patient had had pneumonia, documentation does not point to concerns for which a chest-x-ray would be obtained. Neither does documentation contain a rationale for a medical clearance. The documentation does mention urinary tract infections and a neurogenic bladder which would argue for a UA. The requested treatment: Outpatient medical pre-operative medical clearance and labs including CBC, BMP, UA, PT/PTT, EKG, and CXR is not medically necessary and appropriate.

Cold therapy unit 30 day rental: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chronic Pain Treatment Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck Chapter-cold packs, continuous flow cryotherapy l.

Decision rationale: The ODG guidelines do recommend cold packs for the first few days of symptoms. However, continuous-flow cryotherapy is not recommended in the neck. The requested treatment: Cold therapy unit 30 day rental is not medically necessary and appropriate.

Purchase of pneumatic intermittent compression device: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chronic Pain Treatment Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee replacement chapter-venous thrombosis.

Decision rationale: The ODG guidelines do recommend mechanical compressive devices for hip and knee replacement but do not mention cervical surgery. The guidelines note that compressive devices do lower the risk of deep venous thrombosis. But the guidelines note there is no evidence the devices lower the risk of fatal pulmonary embolism. The requested treatment: Purchase of pneumatic intermittent compression device is not medically necessary and appropriate.

Ongoing home health care 12 hours a day, 7 days a week for 6 months: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chronic Pain Treatment Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) spinal fusion chapter-home services.

Decision rationale: The ODG guidelines recommend home health services for recommended medical treatment. Documentation does not contain evidence of what medical treatment is expected to last six months. Requested Treatment: Ongoing home health care 12 hours a day, 7 days a week for 6 months is not medically necessary and appropriate.

Dilaudid 4mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints,Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opiods for osteoarthritis; opiods for neuropathic pain Page(s): 83. 82.

Decision rationale: In that the request for treatment is more than two weeks after the surgical procedure according to the documentation, the opioid Dilaudid would not be recommended as first line therapy for osteoarthritis according the California MTUS guidelines. It would also not be recommended as a first line therapy for neuropathic pain. The requested treatment: Dilaudid 4mg #120 is not medically necessary and appropriate.

Xanax #30 (dosage not specified): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

Decision rationale: The California MTUS guidelines do not recommend benzodiazepines for long term use. They note most guidelines limit use to 4 weeks. They note that a more appropriate choice would be an antidepressant. The requested treatment: Xanax #30 (dosage not specified) is not medically necessary and appropriate.