

Case Number:	CM15-0030747		
Date Assigned:	02/24/2015	Date of Injury:	03/01/2011
Decision Date:	04/17/2015	UR Denial Date:	01/30/2015
Priority:	Standard	Application Received:	02/18/2015

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: Oregon, California
 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 51-year-old female who reported an injury on 03/01/2011. The mechanism of injury was not provided. Prior therapies included physical therapy and facet injections, physical therapy, a brace, medications and Orthovisc injections. The injured worker was noted to undergo an MRI of the cervical spine on 12/04/2014. The MRI of the cervical spine with flexion and extension dated 04/14/2012 revealed at C5-6, there was focal central disc protrusion with annular tear effacing the thecal sac having osteophytic complex of the lateral anterior and posterior aspects. There was hypertrophy of the facet joints and uncinat processes noted. There was ligamentum flava demonstrating normal configuration. There was no significant spinal canal, lateral recess, or neural foraminal narrowing. The transiting and exiting nerve roots were unremarkable. The disc measurements measured 1.9 mm in neutral, 2.8 mm in flexion, and 2 mm in extension. The MRI of the cervical spine with flexion and extension on 11/20/2012 revealed at C5-6 there was a 1 mm posterior disc bulge resulting in mild left neural foraminal narrowing. The disc bulge was stable, measuring 1 mm on flexion and extension views. The MRI of the cervical spine without contrast on 07/07/2014 revealed mild degenerative changes of the cervical spine with no significant spinal stenosis. There was no Request for Authorization submitted for review for the requested surgical service. The most recent documentation was dated 01/28/2015. The documentation was related to the injured worker's knee. It was documented the injured worker used a single point cane for stability. The injured worker's current medications included Norco 5/325 mg 1 tablet every 8 hours as needed for pain, tramadol 50 mg 1 twice a day as needed for pain, Vimovo, and Voltaren topical gel. The

physical examination revealed swelling and effusion in the left knee. Diagnosis included knee arthralgia, degenerative osteoarthritis, knee genu varum and varus deformity, and abnormality of gait. The request was made for a total knee arthroplasty. There was no physician documentation related to the requested anterior cervical discectomy and fusion.

IMR ISSUES, DECISIONS AND RATIONALES

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

Anterior C5-6 discectomy and fusion with anterior instrumentation and use of operative microscope: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 180-181.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 179-181.

Decision rationale: The American College of Occupational and Environmental Medicine indicates that a surgical consultation may be appropriate for injured workers who have activity limitation for more than 1 month or with extreme progression of symptoms. There should be documentation of clear clinical, imaging, and electrophysiological 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 efficacy of cervical fusion for injured workers with chronic cervical pain without instability has not been demonstrated. The clinical documentation submitted for review failed to provide documentation of clear clinical imaging and electrophysiologic evidence that consistently indicated the same lesion. There was a lack of documentation of impingement per MRI or objective findings as no objective findings were noted. Given the above, the request for Anterior C5-6 discectomy and fusion with anterior instrumentation and use of operative microscope 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 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.

Pre-operative EKG: 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.

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 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.

Pre-operative CBC: 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.

Pre-operative Chem-7: 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.

Pre-operative PT/INR: 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.

Vimovo 500/20mg #60 with 3 refills QTY: 240: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 22, 68.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 67, 69.

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines indicate that NSAIDS are recommended for short-term symptomatic relief of low back pain. It is generally recommended that the lowest effective dose be used for all NSAIDs for the shortest duration of time consistent with the individual injured worker treatment goals. Proton pump inhibitors are recommended for injured workers at intermediate or high risk for gastrointestinal events. Injured workers with no risk factor and no cardiovascular disease do not require the use of a proton pump inhibitor. Injured workers at high risk for gastrointestinal events with no cardiovascular disease: A Cox-2 selective agent plus a PPI if absolutely necessary. There was a lack of documentation indicating a necessity for both a topical and oral form of NSAID. There was a lack of documented efficacy for the requested medication. There was a lack of documentation indicating a necessity for 3 refills without re-evaluation. There was a lack of documentation of a failure of the individual components to support the necessity for a combination medication. Given the above, the request for Vimovo 500/20mg #60 with 3 refills QTY: 240 is not medically necessary. The request as submitted failed to indicate the frequency for the requested medication.

Voltaren 1% gel apply 4 grams to affected 4x daily as needed 30 grams, dispense 3 Qty 3.00: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation www.PDR.net.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Voltaren Gel Page(s): 12.

Decision rationale: The California Medical Treatment Utilization Schedule guidelines indicate that Voltaren Gel 1% (diclofenac) is an FDA-approved agent indicated for relief of osteoarthritis pain in joints that lends themselves to topical treatment such as the ankle, elbow, foot, hand, knee, and wrist. It has not been evaluated for treatment of the spine, hip, or shoulder. Maximum dose should not exceed 32 g per day (8 g per joint per day in the upper extremity and 16 g per joint per day in the lower extremity). There was a lack of documentation indicating a necessity for both an oral and topical form of NSAID. The objective functional benefit and an objective decrease in pain were not provided. There was a lack of documentation indicating a necessity for 3 refills without re-evaluation. Given the above, the request for Voltaren 1% gel apply 4 grams to affected 4x daily as needed 30 grams, dispense 3 Qty 3.00 is not medically necessary.

Tramadol 50mg #60 with 2 refills QTY: 180: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic pain, ongoing management Page(s): 60, 78.

Decision rationale: The California MTUS Guidelines recommend opiates for the treatment of chronic pain. There should be documentation of objective functional improvement, and objective decrease in pain, and documentation the injured worker is being monitored for aberrant drug behavior and side effects. The clinical documentation submitted for review failed to provide documentation including objective functional pain relief, an objective decrease in pain, and documentation the injured worker was being monitored for aberrant drug behavior and side effects. The request as submitted failed to indicate the frequency for the requested medication. There was a lack of documentation indicating a necessity for 2 refills without re-evaluation. Given the above, the request for Tramadol 50mg #60 with 2 refills QTY: 180 is not medically necessary.

Norco 5/325mg #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic pain, ongoing management, opioid dosing Page(s): 60, 78, 86.

Decision rationale: The California MTUS Guidelines recommend opiates for the treatment of chronic pain. There should be documentation of objective functional improvement, and objective decrease in pain, and documentation the injured worker is being monitored for aberrant drug behavior and side effects. The clinical documentation submitted for review failed to provide documentation including objective functional pain relief, an objective decrease in pain, and documentation the injured worker was being monitored for aberrant drug behavior and side effects. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Norco 5/325mg #120 is not medically necessary.