

<b>Case Number:</b>	CM15-0081337		
<b>Date Assigned:</b>	05/04/2015	<b>Date of Injury:</b>	07/17/2014
<b>Decision Date:</b>	07/09/2015	<b>UR Denial Date:</b>	04/14/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/28/2015

### 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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 54 year old who sustained an industrial injury on 07/17/2014. Diagnoses include herniated cervical spine at C4-C5, C5-C6, and C6-C7, cervical stenosis, cord impingement, myelopathy and discogenic headaches. Treatment to date has included diagnostic studies, medications, and therapies. A physician progress note dated 03/02/2015 documents the injured worker has significant cervical spine pain and discomfort, loss of range of motion of the cervical spine with painful range of motion, weakness in the upper extremities with disc herniation at C4-C5 is 4.5mm, C5-C6 is 4.2mm, and C6-C7 is 3.3mm with stenosis. The injured worker has loss of range of motion in the cervical spine, weakness in the upper extremities bilaterally C5 greater than C6 and C7. Treatment requested is for Bone stimulator for purchase, Cold unit rental for 7 days, post cervical collar for purchase, post-operative office visit, and post-operative physical therapy 2 times a week for 4 weeks for the cervical spine.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Post-operative office visit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, 2nd Edition (2004), Independent medical examination and consultations. Ch: 7, page 127.

**Decision rationale:** The patient presents with significant cervical spine pain and discomfort. The physician is requesting POST-OPERATIVE OFFICE VISIT. The RFA dated 03/11/2015 shows a request for post-op office visits with [REDACTED]. The patient is temporarily totally disabled. ACOEM, second edition 2004 chapter 7, page 127 states that "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 examinees fitness for return to work." Per the 03/02/2015 report, the physician is requesting Anterior Cervical Discectomy and Fusion at C4-C5, C5-C6 and C6-C7. The UR dated 04/14/2015 noted that the requested cervical fusion surgery was denied. While the guidelines support specialty follow up evaluations following surgery, the patient's cervical fusion was not authorized. Therefore, post-operative office visit would not be warranted. The request IS NOT medically necessary.

**Cold unit rental for 7 days:** 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), Neck & Upper Back, Cold packs, Continuous-flow cryotherapy.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Neck and Upper Back Chapter on Continuous-Flow cryotherapy Shoulder Chapter under Continuous-flow cryotherapy.

**Decision rationale:** The patient presents with significant cervical spine pain and discomfort. The physician is requesting COLD UNIT RENTAL FOR 7 DAYS. The RFA dated 03/11/2015 shows a request for cold unit rental 7 days. The patient is temporarily totally disabled. The ODG Guidelines under the Neck and Upper Back Chapter on Continuous-Flow cryotherapy states, "Not recommended in the neck. Recommended as an option after shoulder surgery, but not for non-surgical treatment. Postoperative use generally may be up to 7 days, including home use." ODG-TWC, Shoulder Chapter under Continuous-flow cryotherapy states: "Recommended as an option after surgery but not for nonsurgical treatment. Postoperative use generally may be up to 7 days including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic use. However, the effectiveness on more frequently treated acute injuries has not been fully evaluated." The physician does not provide a rationale for this request. It would appear that the request for Cold Unit rental is following the request for Anterior Cervical Discectomy and Fusion which was denied. In this case, cold therapy units are not recommended for the neck. Furthermore, the patient's cervical fusion surgery was not authorized; therefore the use of a cold therapy unit following surgery is not warranted. The request IS NOT medically necessary.

**Bone stimulator for purchase: 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), Low Back, Bone growth stimulators.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Neck & Upper Back Chapter, under Bone-growth stimulators (BGS) Low Back Chapter under Bone growth stimulators (BGS).

**Decision rationale:** The patient presents with significant cervical spine pain and discomfort. The physician is requesting BONE STIMULATOR FOR PURCHASE. The RFA dated 03/11/2015 shows a request for Bone Stim. The patient is temporarily totally disabled. ODG Guidelines, Neck & Upper Back Chapter, under Bone-growth stimulators (BGS) has the following: Under study. See the Low Back Chapter for more information about use in spinal fusion. ODG Guidelines, Low Back Chapter under Bone growth stimulators (BGS) states: 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; or (6) Significant osteoporosis which has been demonstrated on radiographs. (Kucharzyk, 1999) (Rogozinski, 1996) (Hodges, 2003) The report making the request was not provided for review. The 03/02/2015 treatment report shows a request for ACDF surgery. It appears that the request for a bone stimulator would be used following cervical fusion. However, the UR dated 04/14/2015 documents that the ACDF surgery was denied. Furthermore, there is no documentation that patient presents with high risk factors such as smoking, osteoporosis, diabetes, or renal disease. Therefore, the request IS NOT medically necessary.

**Post cervical collar for purchase: 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), Cervical collar, post operative (fusion).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 175. Decision based on Non-MTUS Citation Official disability guidelines Neck and Upper Back Chapter, Cervical Collar.

**Decision rationale:** The patient presents with significant cervical spine pain and discomfort. The physician is requesting POST CERVICAL COLLAR FOR PURCHASE. The RFA dated 03/11/2015 shows a request for post cervical collar. The patient is temporarily totally disabled. The ACOEM chapter 8 page 175 states, "Cervical collars: Initial care - other miscellaneous therapies have been evaluated and found to be ineffective or minimally

effective. For example, cervical collars have not been shown to have any lasting benefit, except for comfort in the first few days of clinical course in severe cases; in fact, weakness may result from prolonged use and will contribute to debilitation. Immobilization using collars in prolonged periods of rest are generally less effective than having patients maintain their usual, 'pre-injury' activities." Regarding cervical collars, the ODG Guidelines, Neck and Upper Back Chapter, under Cervical Collar states, "Maybe appropriate where post-operative and fracture indications exist." The physician does not discuss this request. It appears that this request was made following the request for cervical fusion surgery. But the utilization review dated 04/14/2015 notes that the request for ACDF surgery was denied. ACOEM guidelines do not support cervical collars and ODG states it may be appropriate for post-operative use or when there is a fracture. Given that the ACDF surgery was not authorized, post-operative cervical collar would not be warranted. The request IS NOT medically necessary.

**Post-operative physical therapy 2 times a week for 4 weeks for the cervical spine: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 26.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine Page(s): 98-99.

**Decision rationale:** The patient presents with significant cervical spine pain and discomfort. The physician is requesting POST-OPERATIVE PHYSICAL THERAPY 2 TIMES A WEEK FOR 4 WEEKS FOR THE CERVICAL SPINE. The RFA dated 03/11/2015 shows a request for post-surgery physical therapy 2 times a week for 4 weeks. The patient is temporarily totally disabled. The MTUS Guidelines page 98 and 99 on physical medicine recommends 8 to 10 visits for myalgia, myositis and neuralgia type symptoms. The utilization review dated 04/14/2015 documents that the request for cervical fusion was not authorized. The physician does not discuss this request. In this case, given that the request for ACDF was denied, the request for post-operative physical therapy would not be warranted. The request IS NOT medically necessary.