

Case Number:	CM14-0137830		
Date Assigned:	09/05/2014	Date of Injury:	07/30/2010
Decision Date:	10/14/2014	UR Denial Date:	08/13/2014
Priority:	Standard	Application Received:	08/26/2014

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 58-year-old male who reported an injury on 07/30/2010 due to cumulative trauma while performing normal job duties. The injured worker reportedly sustained an injury to his cervical spine. The injured worker was evaluated on 07/25/2014. It was documented that the injured worker's treatment history included physical therapy and a cervical fusion from the C3 to the C4 with chronic pain managed with multiple medications. It was noted that the injured worker underwent a radiograph of the C3-4 that documented there was a fractured screw from the standalone device causing a C4 fatigue fracture and no fixation at the C4 with instability at the C3-4. The physical examination documented a positive Spurling's sign and significant cervical paraspinal spasming and tenderness with decreased motor strength in the left upper extremity. The injured worker's diagnoses included status post anterior posterior fusion and decommission at the L5-S1; status post multilevel anterior cervical fusion; status post left shoulder arthroscopy; right lower extremity radicular pain; left shoulder rotator cuff syndrome; severe spinal cord compression at the C3-4; and status post adjacent level anterior cervical discectomy and fusion at the C3-4. A request was made for a revision of the C3-4 fusion due to the broken hardware and stress fracture at the C4. A Request for Authorization to support the request was submitted on 07/25/2014. The injured worker underwent a CAT scan on 08/08/2014 that documented the injured worker was status post interbody fusion at the C3-4 with broken inferior screw and minimal displacement. The distal aspect of the screw was still within the vertebral body. The injured worker also underwent an MRI on the same day of the cervical spine that documented there was a broken screw with a stress reaction and the superior endplate of the C4 with no evidence of subluxation or central canal stenosis at that level.

IMR ISSUES, DECISIONS AND RATIONALES

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

Posterior Lateral Mass Fixation at C3 and C4: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178, 179-181. Decision based on Non-MTUS Citation Official Disability Guidelines: Cervical Chapter, Cervical Spine: Spinal Fusion Criteria

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

Decision rationale: The requested posterior lateral mass fixation at the C3 and C4 are not medically necessary or appropriate. The clinical documentation submitted for review does indicate that the injured worker underwent an interbody fusion at the C3-4 that ultimately resulted in a broken screw. It was noted that the injured worker had a stress reaction at the superior endplate of the C4. However, the injured worker's most recent imaging study does not provide any evidence of spondylolisthesis or focal cord signal abnormality to support the need for additional surgical intervention. Additionally, the clinical documentation submitted for review does not provide any evidence that the injured worker has significant radicular symptoms that would require further surgical intervention. As such, the requested posterior lateral mass fixation at the C3 and C4 are not medically necessary or appropriate.

Associated surgical service: Assistant Surgeon: 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.

Associated surgical service: Pre-Op Internal Medical Evaluation and 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.

Associated surgical service: Inpatient One Night LOS: Noting Recommendation for surgery: 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.

Associated surgical service: Cervical Orthosis: Cervical Collar: 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.

Associated surgical service: Post Op Physical Therapy and Rehabilitation of Cervical Spine x 24 visits (Noting Recommendation for Surgery): 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.

Flexeral 10mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines Muscle Relaxants for Pain Page(s): 67. Decision based on Non-MTUS Citation Official Disability Guidelines: Pain Chapter

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxers Page(s): 63.

Decision rationale: The requested Flexeril 10 mg #90 is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends a short duration of treatment for acute exacerbations of chronic pain with the use of muscle relaxants. The guideline recommendations do not support the use of muscle relaxants for chronic pain issues. The clinical documentation submitted for review does in that the injured worker has been on this medication for an extended duration. Therefore, continued use would not be supported. Furthermore, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of

this information, the appropriateness of the request itself cannot be determined. As such, the requested Flexeril 10 mg #90 is not medically necessary or appropriate.

Norco 10/325mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 82-88.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-Going Management, Page(s): 78.

Decision rationale: The requested Norco 10/325 mg #30 is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends the ongoing use of opioids in the management of chronic pain be supported by documented functional benefit, evidence of pain relief, managed side effects, and evidence that the injured worker is monitored for aberrant behavior. The clinical documentation submitted for review does not provide any evidence that the injured worker is monitored for aberrant behavior or that there is significant functional benefit or painful resulting from the use of this medication. Furthermore, the request as it is submitted does not clearly identify a frequency or treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Norco 10/325 mg #30 is not medically necessary or appropriate.