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| Case Number: | CM14-0149469 | | |
| Date Assigned: | 10/20/2014 | Date of Injury: | 04/16/2014 |
| Decision Date: | 12/18/2014 | UR Denial Date: | 09/04/2014 |
| Priority: | Standard | Application Received: | 09/15/2014 |

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 Spine Surgeon, 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 35-year-old male who reported an injury on 04/16/2014. The mechanism of injury occurred when the injured worker was pulling a glass coffee table and strained his upper back and neck. Diagnoses included herniated nucleus pulposus at C5-6 with myelopathy, radiculopathy, and cervical sprain. Previous treatments included medication. Diagnostic testing included an MRI of the cervical spine dated 07/18/2014 which was noted to reveal a C5-6 posterior 2 mm disc protrusion. No spinal stenosis, foraminal narrowing, or neural compression were noted. Within the clinical note dated 08/13/2014, it was reported that the injured worker complained of pain rated 9/10 in severity without medication, and 5/10 with medication. He reported severe pain in the neck radiating to the arms with weakness, numbness, and tingling in the bilateral upper extremities. The injured worker reported dropping items with his left hand. He reported starting physical therapy. However, he stopped due to aggravation of his symptoms. On physical examination, the provider noted the injured worker's bilateral upper extremities with 4/5 weakness and numbness on the left at C6, as well as hyperreflexia in both knees and ankles. The injured worker had positive cervical tenderness, with muscle spasms noted in the paraspinal musculature. The cervical range of motion was decreased by 40%. The injured worker had a positive left sided Spurling's test. The provider requested anterior cervical decompression and instrumented fusion at the C5-6 level with allograft bone, interbody cage, and anterior cervical plating, a surgical assist, a cervical postoperatively, hot/cold therapy postoperatively, and muscle stimulator postoperatively. The provider also requested refills on Celebrex, Norco, and Neurontin. The provider requested the surgery due to progressive neurological deficits and evidence of myelopathy. A Request for Authorization was submitted and dated 08/14/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hot/cold therapy unit: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Continuous- flow cryotherapy.

Decision rationale: The request for hot/cold therapy unit is not medically necessary. The Official Disability Guidelines recommend continuous flow cryotherapy as an option after surgery, but not for nonsurgical treatment. Postoperative use may be generally up to 7 days, including home use. The clinical documentation submitted failed to indicate the number of days the injured worker is to utilize the hot/cold therapy unit. Therefore, the request is not medically necessary.

Muscle stimulator: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy Page(s): 114-116.

Decision rationale: The request for muscle stimulator is not medically necessary. The California MTUS Guidelines do not recommend a TENS unit as a primary treatment modality. A 1 month home based TENS trial may be considered as a noninvasive conservative option if used as an adjunct to a program of evidence based functional restoration. There is evidence that other pain modalities have been tried and failed. The request submitted failed to indicate the length of treatment the injured worker is to utilize the muscle stimulator. The request submitted failed to provide whether it is for rental or purchase. The request submitted failed to provide a treatment site. Therefore, the request is not medically necessary.

Cervical collars: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck & Upper Back, Collars (cervical)

Decision rationale: The request for cervical collars is not medically necessary. The Official Disability Guidelines do not recommend cervical collars for neck sprains. The Guidelines note

immobilization using collars are less effective and not recommended for treating patients with whiplash. The guidelines note it may be appropriate where postoperative and fracture indications exist. The request submitted failed to provide the length of time the injured worker is to utilize the cervical collar. Additionally, the guidelines do not recommend the utilization of a cervical collar for immobilization. Therefore, the request is not medically necessary.

Celebrex 200mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 67-68.

Decision rationale: The request for Celebrex 200mg #30 is not medically necessary. The California MTUS Guidelines recommend non-steroidal anti-inflammatory drugs at the lowest dose for the shortest period of time. The guidelines note that NSAIDs are recommended for the signs and symptoms of osteoarthritis. There is a lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. Therefore, the request is not medically necessary.

Norco 10/325 mg #90: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, On-Going Management Page(s): 77, 78.

Decision rationale: The request for Norco 10/325 mg #90 is not medically necessary. The California MTUS Guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The guidelines recommend the use of urine drug screen or inpatient treatment with issues of abuse, addiction, or poor pain control. There is a lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The provider failed to document an adequate and complete pain assessment within the documentation. Additionally, the use of a urine drug screen was not submitted for clinical review. Therefore, the request is not medically necessary.