

Case Number:	CM14-0191322		
Date Assigned:	11/25/2014	Date of Injury:	06/10/2003
Decision Date:	01/09/2015	UR Denial Date:	10/30/2014
Priority:	Standard	Application Received:	11/17/2014

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 Dentistry and is licensed to practice in California. 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:

This 63 year old female continues to have continued complaints of severe lower back pain stemming from a reported work related injury reported on 6/10/2003. Chronic use of opioids, stemming from this injury, resulted in a diagnosis of severe xerostomia and tooth decay, and leading to a request, on 10/23/2014, for implant Bar-5 implants (dentures) for teeth #23, 24, 27 and 28 for which have already been extracted; and an implant authorized to tooth #23. Diagnoses include mild degenerative disc bulging without significant stenosis or exiting nerve roots at lumbar (L) 3-L4, L4-L5 and L5-sacral (S) 1; moderate degenerative spinal canal stenosis at cervical (C) 4-C5; cortical and subcortical encephalomalacia and old right thalamic lacunar infarct; and depression. Treatments have included consultations; laboratories, diagnostic and imaging studies with MRI and electromyogram; epidural steroid injections; medication management; dental work and oral surgeries. The injured worker (IW) is noted to be permanent and stationary. Progress notes, dated 5/13/2014, note subjective complaints that include lower back and left leg pain, as well as experiencing complications stemming from a recent EMG nerve conduction study that caused damage to the nerves in her left leg and left arm. The IW also stated that she feels her pain, and "toxic" medications that she received in the hospital, have caused decay of her teeth, and that she experiences intolerance to several medications that she has been prescribed to include Hydrocodone, Oxycontin, Trazodone, Soma and Opana. Objective findings note some tooth decay in the lower anterior portion of the mouth, tenderness in the central lumbosacral area over the central aspect of the sacrum, pain with a mild decrease in active range of motion, and an otherwise normal inspection of the lumbar spine. Sensory and motor assessments, and deep tendon reflexes, were noted to be grossly normal. Assessment findings note the IW displaying, being, very frustrated towards, and had lost patience with, the medical system; and that she was very dissatisfied with her doctors who were unable to take care

of and remove her pain. Symptomatic low back pain and moderate cervical stenosis were thought to be a possible cause of her ongoing left arm pain. Significant cerebrovascular disease and changes in mental status were felt to potentially stem from old infarcts, drastically affecting the IW perception of her injury. Recommendations included continued conservative medical treatment along with continued support and encouragement to remain active, and medication management with Celebrex, and Soma; with Ultram for flare-ups. Progress notes, dated 6/17/2014, show no significant changes in her subjective complaints of pain, except for an increased amount of knee pain that is unrelated to this work injury, and that she continues to state issues stemming from the EMG several months prior. She is noted to remain quite frustrated at her pain and in not receiving any pain medications from her specialists. No significant change in objective findings were noted, and Soma and Voltaren were prescribed. Progress notes, dated 10/8/2014, noted continued complaints of moderate back pain with some radiating pain into the legs, and of significant pain in the right sacroiliac joint. Review of the 10/6/2014 MRI of the lumbar, noted a new, small disc protrusion or herniation at L4-L5 for which an ultrasound guided epidural injection was recommended, and given, to help in resolve some of the radiculopathy. No medications were noted prescribed. Except for a letter, dated 10/23/2014, from the claims adjuster at the oral surgeon's office, all medical progress notes submitted for my review of this claim address the IW stated complaints of ongoing left-sided lower back pain that radiates over her sacrum and down into the leg. This letter states that the restoring dentist determined that teeth # 22, 23, 27 & 28 are non-restorable and will need to be extracted. Clinical notes, dated 10/24, note the chief complaint to be that the IW had multiple teeth extracted and implants placed. Objective findings noted that Soma was noted listed in the medication history, and that "she was on serious pain meds causing her teeth to turn black, so they have all been extracted except #21,22,27 & 28"; and that these teeth are decayed or have faulty restorations of them. The operative report, dated 10/29/2014, noted the IW underwent a successful ultrasound of the pelvis and extremity, and ultrasonic guidance for spinal needle placement into the left sacroiliac joint; without complication. On 10/30 2014, Utilization Review non-certified, for medical necessity, a request for Implant Bar 5 Implants citing previous authorization for bone grafts, surgical extractions and subsequent implants of multiple teeth, and that it is unclear if the injured worker underwent these treatments, authorized on 5/30/2014, for the purpose of treating the IW problems completely. It was noted that the most current medical records provided for this review, did not clarify current dental findings or the history of all the dental treatments the IW underwent; why the denture was now being requested, or why the dental treatment had been changed. The Official Disability Guidelines, Head Chapter, recommendations were cited in this decision. Authorization was previously provided for bone grafts, surgical extractions and implants on multiple teeth. Clinical notes of doctor indicate that teeth # 21, 22, 27, 28 are decayed and/or have faulty restorations on them. Doctor plans to extract number 21, 22, 27 and 28 and uncover the upper implants. And then patient will be ready for a maxillary bar on five implants and mandibular bar on four implants with upper and lower dentures.

IMR ISSUES, DECISIONS AND RATIONALES

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

Implant Bar-5 Implants: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Aetna Clinical Policy Bulletin

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines ODG Head(updated 06/04/13)

Decision rationale: Based on the records reviewed, medical articles mentioned above, and findings of doctor summarized above, this IMR reviewer finds this request for Implant Bar-5 implants to be medically necessary to prepare this patient's mouth for dentures to restore her functional chewing ability.