

Case Number:	CM14-0211695		
Date Assigned:	02/03/2015	Date of Injury:	06/25/2010
Decision Date:	03/09/2015	UR Denial Date:	11/25/2014
Priority:	Standard	Application Received:	12/17/2014

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. 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: Minnesota, Florida

Certification(s)/Specialty: Orthopedic 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:

This is a 66 year old male with a previous work injury. He stated that he had neck pain related to prolonged sitting in front of the computer, repetitive use of his arm and hands in front of the plane of his body and repetitive or sustained neck flexion activities as a result of work activities in 2005. He stated on January 2014 he noted an increase in neck and upper back pain as well as pain and numbness to his forearms and hands. On 10/28/2014 the IW presented for a follow up at which time he was complaining of intermittent moderate low back pain with pain shooting down the right leg. He stated the pain interrupted his sleep and he had started sleeping on the floor. The IW had been seeing a chiropractor three times a week which had helped with numbness in his extremities. Physical exam revealed tenderness to palpation over the para-cervical and trapezius muscles at cervical (C) 7 - thoracic(T) 1. Restricted ranges of motion and muscle spasm were noted. Cervical distraction test was positive. Examination of the lumbar spine revealed tenderness to palpation over the right para-lumbar musculature. There was a positive straight leg raise on the right. There was restricted range of motion and muscle spasms of the lumbar spine. MRI done on 08/08/2014 showed the following: C1-C2 moderate degenerative changes of the atlanto-odontoid articulation. The tectorial membranes are normal. The clivus is normal C2-C3 There is disk desiccation. Left facet fusion is noted. The posterior margin of the disk, thecal sac and neural foramina appear normal. C3-C4 There is disk desiccation with 2 mm anterolisthesis. There is a 3 mm posterior disk bulge with bilateral uncinated spondylosis. Bilateral facet hypertrophy is seen. There is mild narrowing of thecal sac. Moderate to severe bilateral neural foraminal narrowing is noted. C4-C5 There is disk

desiccation with mild disk narrowing and posterior endplate changes. 2 mm anterolisthesis is seen with a 3-4 mm posterior disk bulge. Bilateral uncinated spondylosis and facet hypertrophy is noted. There is prominence of the ligamentum flavum. There is moderate narrowing of thecal sac with mild flattening of the spinal cord. Severe bilateral neural foraminal narrowing is noted.- C5-C6 - There is disk desiccation with moderate disk narrowing. There is 1 mm anterolisthesis. There is a 1.2 mm posterior disk osteophyte complex with bilateral uncinated spondylosis, right more than left. Right facet fusion is noted. Severe right neural foraminal narrowing is noted. There is mild left neural foraminal narrowing. C 6-C7 There is disk desiccation with severe disk narrowing. There is a 5 mm posterior disk osteophyte complex with bilateral uncinated spondylosis. Bilateral facet hypertrophy is seen. There is mild narrowing of the midline thecal sac and severe bilateral neural foraminal narrowing.C7-T1 There is disk desiccation. The posterior margin of the disk and thecal sac appear normal. There is right facet hypertrophy with mild right neural foraminal narrowing.Diagnoses included:- Cervical spine sprain/strain- Lumbar spine sprain/strain - MRI evidence of 3mm disc bulge at lumbar (L)1 - L2, 2 - 3 mm disc bulge at L3 - L4 and 7 mm anterolisthesis at L 5 - sacral (S) 1.- GastritisThe provider requested anterior cervical disc fusion of C3-4, C4-5, C5-6 and C6-7, cervical soft collar/brace, post-operative cryotherapy 1 month at 3-5 times per day, bone stimulator, pre-operative medical clearance and assistant surgeon. Omeprazole 20 mg # 60 and Xanax 0.25 mg were requested. On 11/25/2014 utilization review non-certified the request for surgery stating: California MTUS and ACOEM support surgery in the presence of clear clinical imaging and electrophysiological evidence consistently indicating the same lesion shown to benefit from surgical repair. In this case, there are significant imaging findings, but there are no positive clinical and electrodiagnostic findings to corroborate cervical radiculopathy at the proposed surgical levels. As such the surgery and associated requests are recommended non-certified. Regarding Omeprazole utilization review states California MTUS supports the use of this medication for patients with a high risk of gastrointestinal complications or with dyspepsia secondary to non-steroidal anti-inflammatory drug (NSAID) use. It is also supported in the management of conditions such as gastroesophageal reflux disease. None of these conditions are documented and the request is non-certified. Regarding Xanax utilization review states per California MTUS benzodiazepines are not recommended for long term use. As long term use is not supported and there is no clear rationale presented for the use of this medication the request is recommended non-certified.Guidelines cited: ACOEM Practice Guidelines 2nd Ed. 2004, Chapter 8, Neck and Upper back Complaints, Surgical Considerations; California MTUS Chronic Pain Medical Treatment Guidelines NSAID's, GI symptoms & cardiovascular risk; California MTUS Medical Treatment Guidelines regarding Benzodiazepines. The request was appealed to Independent Medical Review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Anterior cervical disc fusion of C3-4, C4-5, C5-6, & C6-7: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 179, 180, 181.

Decision rationale: The agreed medical reevaluation of December 9, 2014 is reviewed. A detailed examination of the spine and upper extremities was performed on December 9, 2014. Neurologic examination of the upper extremities revealed no atrophy. Motor examination revealed 5/5 muscle strength in all muscle groups. Sensation was intact in all dermatomes. Range of motion of the cervical spine was limited with flexion limited to 60% and extension 50%. Deep tendon reflexes were 2+ bilaterally. No neurologic deficit was documented in the upper extremities. The examiner opined that surgery was a bad choice and should be a last resort. A January 6, 2015 report indicates the subjective complaints of intermittent moderate neck pain radiating down the right arm with occasional numbness in the right hand. No sensory deficit was noted in the upper extremities. There was 5/5 muscle strength in all muscle groups and 2+ deep tendon reflexes in both upper extremities. The diagnosis was cervical spine sprain/strain. Although the MRI findings of 8/8/2014 are significant at multiple levels as noted above, the clinical examination does not reveal significant neurologic deficit at these levels. Also there is no electrodiagnostic evidence of radiculopathy corroborating the imaging studies at these levels. The California MTUS guidelines indicate surgical considerations for severe spinal vertebral pathology, severe debilitating symptoms with physiologic evidence of specific nerve root or spinal cord dysfunction corroborated on appropriate imaging studies that did not respond to conservative therapy, persistent, severe, and disabling shoulder or arm symptoms, activity limitation for more than one month or with extreme progression of symptoms, and clear clinical, imaging, and electrophysiologic evidence, consistently indicating the same lesion that has been shown to benefit from surgical repair in both the short and long-term, and unresolved radicular symptoms after receiving conservative treatment. The presence of a herniated cervical or upper thoracic disc on an imaging study does not necessarily implied nerve root dysfunction. Studies of asymptomatic adults commonly demonstrate intravertebral disc herniations that the permanent 8 do not cause symptoms. In light of the above, the guidelines requirements have not been met and as such, the request for anterior cervical discectomy and fusion at C3-4, C4-5, C5-C6, and C6-7 is not supported and the medical necessity is not substantiated.

Associated surgical service: Assistant surgeon: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 179, 180, 181.

Decision rationale: The requested surgery is not medically necessary. therefore the ancillary services are not applicable.

Associated surgical service: Cervical soft collar/ brace: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 179, 180, 181.

Decision rationale: The requested surgery is not medically necessary. therefore the ancillary services are not applicable.

Pre-operative medical clearance: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 179, 180, 181.

Decision rationale: The requested surgery is not medically necessary. therefore the ancillary services are not applicable.

Post-operative cyrotherapy one (1) month 3-5 times per day: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 179, 180, 181.

Decision rationale: The requested surgery is not medically necessary. therefore the ancillary services are not applicable.

Associated surgical service: Bone stimulator: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 179, 180, 181.

Decision rationale: The requested surgery is not medically necessary. therefore the ancillary services are not applicable.

Omeprazole 20mg #60: Upheld

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

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

Decision rationale: The risk factors for gastrointestinal events include age over 65, history of peptic ulcer, GI bleeding or perforation, concurrent use of aspirin, corticosteroids, and/or an anticoagulant, or high-dose/multiple NSAIDs. A history of ulcer complications is the most important predictor of future ulcer complications associated with NSAID use. Proton pump inhibitors are recommended for patients at intermediate risk for gastrointestinal events and for patients at high risk for gastrointestinal events. The documentation indicates no GI evaluation has been undertaken although there was a history of gastritis in the past. As such, the risk factors have not been identified and the medical necessity of omeprazole 20mg # 60 is not established.

Xanax 0.25mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

Decision rationale: Chronic pain guidelines indicate benzodiazepines are not recommended for long-term use. Most guidelines limited use to 4 weeks. Chronic benzodiazepines are the treatment of choice in very few conditions. A more appropriate treatment for anxiety disorder is an antidepressant. As such, the request for Xanax is not supported by guidelines and the medical necessity is not established.