

Case Number:	CM14-0216391		
Date Assigned:	01/06/2015	Date of Injury:	08/19/2014
Decision Date:	02/28/2015	UR Denial Date:	11/25/2014
Priority:	Standard	Application Received:	12/24/2014

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: Iowa, Illinois, Hawaii

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & Gen Prev Med

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 sustained a work related injury on June 19, 2014. The exact mechanism of the work related injury and affected body parts were not included in the documentation provided. A lumbar spine MRI dated August 15, 2014 was noted to show discogenic spondylosis at L3-L4, L4-L5, and L5-S1, apophyseal joint arthrosis L5-S1, right convexity, lower thoracic and upper lumbar spine, and multiple surgical clips obliquely oriented on the left anterior to L5-S1. The Primary Treating Physician's report dated October 24, 2014, noted the injured worker with complaints of increasing pain at an 8/10 intensity, with numbness in the left arm, low back pain that was not resolving, and left leg radiculopathy. The Physician noted notable weakness in the left triceps. The diagnoses were listed as L4 and L5 and L5 and S1 herniated disc 3-4mm stenosis, degenerative disc disease L4-L5 and L5-S1, cervical spondylosis, lumbar stenosis, herniated disc C4 and C5, C5, C6 and C7, a 6mm C6-C7 herniated disc extending into left foramen, and C6 and C7 left arm radiculopathy. The Physician noted the injured worker with progressive motor deficits of the left arm and was in need of a C6-C7 anterior cervical discectomy and fusion for failed conservative treatment modalities. The Physician requested authorization for a C6-C7 anterior discectomy and fusion, a Solace IF unit as a monthly rental for five months for the spine, and a pain management consultation for medication management and possible epidural injections for the lumbar spine. On November 25, 2014, Utilization Review evaluated the requests for a C6-C7 anterior discectomy and fusion, a Solace IF unit as a monthly rental for five months for the spine, and a pain management consultation for medication management and possible epidural

injections for the lumbar spine, citing the MTUS Chronic Pain Medical Treatment Guidelines, and the MTUS American College of Occupational and Environmental Medicine (ACOEM). The UR Physician noted that interferential stimulation was supported by the guidelines only when pain was ineffectively controlled due to diminished effectiveness of medications, pain is ineffectively controlled with medications due to side effects, a history of substance abuse, significant pain from postoperative conditions limiting the ability to perform exercise programs/physical therapy treatment, or being unresponsive to conservative measures such as repositioning, heat, ice, etc. The UR Physician noted that none of these conditions had been clearly documented and as such the request for a Solace IF unit as a monthly rental for five months for the spine was not medically necessary and was non-certified. The UR Physician noted there was no documentation of an EMG/NCS study to corroborate imaging and clinical findings, or documentation of an ESI to confirm the pain generator, and no documentation of a course of physical therapy prior to surgical consideration, therefore the request for a C6-C7 anterior discectomy and fusion was non-certified. The UR Physician noted that a pain consultation would be appropriate, however the need for any specific treatment would depend in part on the results of the consultation weighed against the appropriate evidence based criteria, therefore the request for a pain management consultation for medication management and possible epidural injections for the lumbar spine was modified to approval for the consultation only. The decisions were subsequently 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:

Solace IF unit for the spine (5 month rental): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation, Transcutaneous electrotherapy Page(s): 54, 114-116, 118-120.

Decision rationale: ACOEM guidelines state "Insufficient evidence exists to determine the effectiveness of sympathetic therapy, a noninvasive treatment involving electrical stimulation, also known as interferential therapy. At-home local applications of heat or cold are as effective as those performed by therapists." MTUS further states regarding interferential units, "Not recommended as an isolated intervention" and details the criteria for selection: - Pain is ineffectively controlled due to diminished effectiveness of medications; or - Pain is ineffectively controlled with medications due to side effects; or - History of substance abuse; or - Significant pain from postoperative conditions limits the ability to perform exercise programs/ physical therapy treatment; or- Unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.). "If those criteria are met, then a one-month trial may be appropriate to permit the physician and physical medicine provider to study the effects and benefits."The treating physician has failed to provide documentation to meet the above guideline recommendations at this time.

C6-7 anterior cervical discectomy and fusion: 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): 177-188. Decision based on Non-MTUS Citation Neck and Upper back;Cervical Fusion and Discectomy-laminectomy

Decision rationale: ACOEM states within the first three months of onset of potentially work-related acute neck and upper back symptoms, consider surgery only if the following are detected: Severe spinovertebral 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. A disk herniation characterized by protrusion of the central nucleus pulposus through a defect in the outer annulus fibrosis may impinge on a nerve root causing irritation, shoulder and arm symptoms, and nerve root dysfunction. The presence of a herniated cervical or upper thoracic disk on an imaging study, however, does not necessarily imply nerve root dysfunction. Studies of asymptomatic adults commonly demonstrate intervertebral disk herniations that apparently do not cause symptoms. The treating physician has failed to fully detail a trial and failure of conservative therapy and has not provided medical imaging and electro diagnostic studies to detail nerve root dysfunction. The patient is to be evaluated by a pain specialist and may be a candidate for epidural steroid injections. The treating physician has not met the above guidelines at this time.

Pain management consultation for medication management and possible epidural injections for the lumbar spine: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM for Independent Medical Examinations and Consultations regarding Referrals, Chapter 7

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

Decision rationale: ODG states concerning office visits "Recommended as determined to be medically necessary. Evaluation and management (E&M) outpatient visits to the offices of medical doctor(s) play a critical role in the proper diagnosis and return to function of an injured worker, and they should be encouraged. The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The determination is also based on what medications the patient is taking, since some medicines such as opiates, or medicines such as certain antibiotics, require close monitoring. As patient conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. The determination of necessity for an office visit requires individualized case review and assessment, being ever mindful that the best patient outcomes are achieved with eventual patient independence from the health care system through self-care as soon as clinically feasible". ACOEM states in the neck and upper back section "Referral for surgical consultation is indicated for patients who have:

Persistent, severe, and disabling shoulder or arm symptoms; Activity limitation for more than one month or with extreme progression of symptoms; 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; Unresolved radicular symptoms after receiving conservative treatment". While a consultation to a pain management specialist would be appropriate, approval of an epidural steroid injection prior to the specialist evaluation of the patient would not be appropriate. As such, the request for Pain management consultation for medication management and possible epidural injections for the lumbar spine is not medically necessary.