

Independent Medical Review Final Determination Letter

[REDACTED]
[REDACTED]
[REDACTED]

Dated: 12/17/2013

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/8/2013
Date of Injury: 5/29/2007
IMR Application Received: 7/31/2013
MAXIMUS Case Number: CM13-0005146

DEAR [REDACTED]

MAXIMUS Federal Services has completed the Independent Medical Review (“IMR”) of the above workers’ compensation case. This letter provides you with the IMR Final Determination and explains how the determination was made.

Final Determination: UPHOLD. This means we decided that none of the disputed items/services are medically necessary and appropriate. A detailed explanation of the decision for each of the disputed items/services is provided later in this letter.

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers’ Compensation. This determination is binding on all parties.

In certain limited circumstances, you can appeal the Final Determination. Appeals must be filed with the Workers’ Compensation Appeals Board within 30 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4610.6(h).

Sincerely,

Paul Manchester, MD, MPH
Medical Director

cc: Department of Industrial Relations, [REDACTED]
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HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in orthopedic surgery, has a subspecialty in spine surgery 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 physician 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.

DOCUMENTS REVIEWED

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- Application of Independent Medical Review
- Utilization Review Determination
- Medical Records from Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

CLINICAL CASE SUMMARY

The physician reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This patient is a 52-year-old with complaints of pain. No mechanism of injury was described for date of injury of 05/29/2007, as was 05/16/2008. On 01/27/2012, an MRI of the cervical spine was obtained, which revealed at C5-6, there was a disc height that was decreased, there was disc desiccation, and a disc protrusion. The disc protrusion was predominately central to the left. There was compromise to the neural foramen on the left side due to the disc protrusion and the protrusion extended up to the cervical cord, and there was anterior impression of the cervical cord due to this disc protrusion. The patient underwent a left C5-6 transforaminal epidural steroid injection on 01/27/2012, and repeat MRI revealed disc desiccation and disc height loss and a disc protrusion at C5-6, with compromise to the neural foramen on the left, as previously documented. On 09/28/2012, the patient was seen in clinic and the patient had a trace positive Spurling's maneuver on the left at that time.

On 05/30/2013, a followup exam revealed head compression sign remained positive. Electrodiagnostic study dated 07/19/2013 failed to reveal evidence of cervical radiculopathy or peripheral nerve dysfunction. A repeat MRI of the cervical dated 07/24/2013 revealed at C5-6, there was disc desiccation with endplate degenerative changes seen and a 4 mm left paracentral disc osteophyte complex that resulted in flattening of the cervical cord with moderate central canal narrowing. This extended into the left neural foramen, resulting in abutment of the exiting left cervical nerve root with narrowing of the entrance of the left neural foramen. On the last clinical exam on 07/25/2013, it was noted that the patient had a positive foraminal compression test to the left. Diagnosis includes upper extremity overuse tendinitis, left shoulder pain, thoracic outlet syndrome, and cervical discopathy, C5-6 disc herniation, depression, stress, and anxiety, with internal medicine issues and carpal tunnel syndrome.

The plan at that time was to proceed with a C5-6 anterior cervical discectomy and fusion, with use of a cervical collar, Pro-Stim unit, home health evaluation, 2 day hospital stay, post-op evaluation by a nurse, psychological clearance, physical therapy for the cervical spine and upper extremities, post-op Zofran, post-op Duricef, and post-op Norco.

IMR DECISION(S) AND RATIONALE(S)

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

1. C5-C6 anterior cervical discectomy and fusion is not medically necessary and appropriate.

The Claims Administrator based its decision on the Neck and Upper Back Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 8), Table 8-7, which is part of the MTUS, as well as the Official Disability Guidelines, which is not part of the MTUS.

The Physician Reviewer based his/her decision on the Neck and Upper Back Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 8), pages 179 – 181, which is part of the MTUS, as well as the Official Disability Guidelines, neck and upper back chapter, cervical fusion, which is not part of the MTUS.

The Physician Reviewer's decision rationale: According to the Neck and Upper Back Complaints Chapter of the ACOEM Practice Guidelines, referral for surgical consultations are indicated for patients who have persistent severe and disabling shoulder or arm symptoms, activity limitation for more than 1 month, or the extreme progression of symptoms, and they should have clear clinical imaging and electrophysiological evidence, consistently indicating the same lesion has been shown to benefit from surgical repair in both the short and long term. There also should be unresolved radicular symptoms after receiving conservative care. For this employee, the electrodiagnostic test is considered negative for radiculopathy or for peripheral nerve dysfunction. The clinical exam indicates she has a positive cervical compression test, but does not indicate that the employee has neurological dysfunction such as motor weakness, reflex changes, or sensory changes. In addition, the employee has an underlying shoulder condition which may be a pain generator during the clinical exam.

The submitted medical records do not include physical therapy notes to indicate failure of lesser measures in that format. Additionally, the last clinical note is dated 07/25/2013. As such, the current clinical status of this employee is unknown. In addition, a psychosocial evaluation has not been performed as recommended by MTUS/ACOEM. Therefore, MTUS/ACOEM does not specifically address a cervical fusion for radiculopathy. The Official Disability Guidelines, in support of MTUS/ACOEM, does indicate that a cervical fusion may be performed in conjunction with a decompression, although current evidence is conflicting about the benefit of fusion in general. **The request for C5-C6 anterior cervical discectomy and fusion is not medically necessary or appropriate.**

2. cervical collar is not medically necessary and appropriate.

The Claims Administrator based its decision on the Neck and Upper Back Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 8), Table 8-7, which is part of the MTUS, as well as the Official Disability Guidelines, which is not part of the MTUS.

The Physician Reviewer based his/her decision on the **Neck and Upper Back Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 8), page 173, which is part of the MTUS.**

The Physician Reviewer's decision rationale: According to the Neck and Upper Back Complaints Chapter of the ACOEM Practice Guidelines, cervical collars have not been shown to have any lasting benefit, except for the first few days of the clinical course in severe cases. Records do not indicate this employee is in the first few days of her clinical course of this condition. The surgical procedure is not considered medical necessity either. A rationale for a cervical collar at this time has not been provided, as there is no documented instability to the cervical spine that would indicate a need for a cervical collar. **The request for a cervical collar is not medically necessary or appropriate.**

3. Pro-Stim unit is not medically necessary and appropriate.

The Claims Administrator based its decision on the Neck and Upper Back Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 8), Table 8-7, which is part of the MTUS, as well as the Official Disability Guidelines, which is not part of the MTUS.

The Expert Reviewer found that no section of the MTUS was applicable. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Expert Reviewer based his/her decision on Official Disability Guidelines (ODG) neck and upper back chapter, bone stimulator, and low back chapter, which are not part of the MTUS.

The Physician Reviewer's decision rationale: According to the Official Disability Guidelines, this device is currently under study. According to the Official Disability Guidelines, Low Back Chapter, a bone growth stimulator may be considered reasonable under certain conditions, which would include documentation of 1 or more previous failed spinal fusions, grade 3 or worse spondylolisthesis, fusion to be performed at more than 1 level, current smoking habit or alcoholism or other metabolic issues such as diabetes or renal disease. The records provided for this review do not indicate this employee has been diagnosed with alcoholism or other disease such as diabetes. This is for a single-level fusion. The records do not describe the employee's smoking habit. **The request for a Pro-Stim unit is not medically necessary or appropriate.**

4. Home help evaluation is not medically necessary and appropriate.

Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

5. Two day hospital stay is not medically necessary and appropriate.

Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

6. Post-op evaluation by a nurse is not medically necessary and appropriate.

Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

7. Psychological clearance is not medically necessary and appropriate.

The Claims Administrator based its decision on the Neck and Upper Back Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 8), Table 8-7, which is part of the MTUS, as well as the Official Disability Guidelines, which is not part of the MTUS.

The Physician Reviewer based his/her decision on the Neck and Upper Back Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 8), pages 179 – 180, which is part of the MTUS.

The Physician Reviewer's decision rationale: According to the Neck and Upper Back Complaints Chapter of the ACOEM Practice Guidelines, a psychological clearance before surgical interventions such as this is recommended. However, a psychological clearance is not the only factor for which the surgical intervention was non-certified. There was lack of documentation of significant current conservative care in the form of physical therapy and/or individual injections and there is lack of documentation of electrodiagnostic studies confirming evidence of radiculopathy. There is also a lack of significant functional deficits on clinical exam to warrant the surgical procedure. Undergoing a psychological clearance itself would not justify all of the criteria for the proposed surgical procedure. **The request for Psychological clearance is not medically necessary or appropriate.**

8. Physical therapy for cervical spine and upper extremities two times a week for four weeks is not medically necessary and appropriate.

Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

9. Postop Zofran is not medically necessary and appropriate.

Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

10. Postop Duracef is not medically necessary and appropriate.

Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

11. Postop Norco is not medically necessary and appropriate.

Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Disclaimer: MAXIMUS is providing an independent review service under contract with the California Department of Industrial Relations. MAXIMUS is not engaged in the practice of law or medicine. Decisions about the use or nonuse of health care services and treatments are the sole responsibility of the patient and the patient's physician. MAXIMUS is not liable for any consequences arising from these decisions.

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