

<b>Case Number:</b>	CM13-0041948		
<b>Date Assigned:</b>	03/28/2014	<b>Date of Injury:</b>	09/06/2011
<b>Decision Date:</b>	04/29/2014	<b>UR Denial Date:</b>	09/23/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/16/2013

### 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 Surgery has a subspecialty in Fellowship training in Spine Surgery and is licensed to practice in Texas and 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:

The patient is a 53-year-old female who reported an injury on 09/06/2011. The mechanism of injury involved a fall. The patient is diagnosed with significant cervical kyphosis and spondylosis at C5-6, mild left carpal tunnel syndrome and right cubital tunnel syndrome. The patient was seen by [REDACTED] on 09/04/2013. The patient reported ongoing neck and bilateral arm pain. The patient also reported numbness down the biceps and dorsoradial forearms bilaterally. The patient denied motor weakness and atrophy of the muscles as well as paresthesia. Physical examination revealed an unequivocal Spurling's sign on the right and left side, paresthesia in the biceps and dorsoradial forearm, equivocal weakness on the right and left side and diminished grip strength on the left. Treatment recommendations at that time included an anterior cervical discectomy and fusion at C4-5, C5-6 and C6-7.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**CERVICAL SURGERY WITH ANTERIOR CERVICAL DISCECTOMY AND FUSION AT C4-5, C5-6 AND WITH HIP ILIAC CREST BONE GRAFT IN LIGHT OF THE MULTILEVEL FUSION/ASSISTANT SURGEON:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 180.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 179-180. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**Decision rationale:** The California MTUS/ACOEM Practice Guidelines state that referral for surgical consultation may be indicated for patients who have persistent and severe disabling shoulder or arm symptoms; activity limitations for more than 1 month; clear clinical, imaging and electrophysiologic evidence of a lesion; and unresolved radicular symptoms after receiving conservative treatment. The Official Disability Guidelines state that anterior cervical fusion is recommended as an option in combination with anterior cervical discectomy for approved indications. Prior to a discectomy, there must be evidence of radicular pain and sensory symptoms in a cervical distribution that correlates with the involved cervical level, or the presence of a positive Spurling's test. There should also be evidence of motor deficits, reflex changes or positive EMG findings. There must be evidence of a failure to respond to at least 6 to 8 weeks of conservative treatment. As per the documentation submitted, the patient's physical examination does reveal paresthesia, unequivocal weakness and an unequivocal Spurling's sign. However, there were no imaging studies or electrodiagnostic reports submitted for review. There were also no radiographic films submitted for review. Based on the aforementioned points, the patient does not meet the criteria for the requested service. As such, the request is non-certified.

**ONE DAY INPATIENT SURGERY:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 180.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 179-180. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary

**CERVICAL COLLAR:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 180.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 179-180. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**BONE GROWTH STIMULATOR AND FITTING:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 180.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 179-180. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.