

<b>Case Number:</b>	CM13-0049768		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	07/24/2012
<b>Decision Date:</b>	06/03/2014	<b>UR Denial Date:</b>	10/29/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/08/2013

### 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 and is licensed to practice in Texas. 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 57 year old male who reported an injury to his cervical region. The electrodiagnostic studies completed on 03/12/13 revealed findings consistent with the presence of multi-level active lumbar sacral radiculopathy. Findings were also consistent with carpal tunnel syndrome. The MRI of the cervical spine dated 03/12/13 revealed a diffused disc bulge measuring 2-3cm in the C5-6 level, left greater than right. A slight contour deformity was identified. Lateral uncovertebral hypertrophic changes were revealed contributing to the bilateral foraminal stenosis. A 3-4mm broad based disc protrusion was identified at C6-7, greater on the right. Lateral disc osteophyte spurring was also identified, greater on the right. This was contributing to bilateral foraminal stenosis, greater on the right. The AME report completed on 03/20/13 indicates the patient complaining of moderate pain at the cervical spine. The patient rated the pain as slight to moderate secondary to repetitive flexion or extension. The clinical note dated 04/17/13 indicates the patient continuing with cervical region pain. The patient was able to demonstrate 45 degrees of cervical flexion, 45 degrees of extension, 30 degrees of bilateral lateral tilt, and 60 degrees of bilateral rotation. The patient demonstrated 4+/5 strength at the hand intrinsic muscles with 5/5 strength in all other groups. The AME report dated 04/22/13 indicates the patient having complaints of pain at several sites. The note indicates the patient having a medical history dating back to 2000. The note indicates the patient having a positive compression sign with additional complaints of pain on extension. The clinical note dated 07/24/13 indicates the patient continuing with minimal strength deficits at the left hand intrinsic muscles. The clinical note dated 11/08/13 indicates the patient being recommended for an epidural steroid injection at C6-7.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**ANTERIOR CERVICAL DISC FUSION AT C5-7 TO BE PERFORMED AT [REDACTED]**  
[REDACTED]: Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** The documentation indicates the patient complaining of cervical region pain with strength deficits identified in the left hand intrinsic muscles. An ACDF is indicated provided the patient meets specific criteria to include significant findings revealed by clinical exam and the patient has completed all conservative treatments. There is an indication that the patient has been recommended for an epidural steroid injection. However, the results of the injection were not provided. Additionally, no information was submitted regarding the patient's recent completion of any conservative therapies. Given the minimal radiculopathy confirmed by clinical exam with no significant strength deficits identified or reflex changes revealed by clinical exam and taking into account the lack of information regarding the patient's completion of all conservative treatments, this request is not indicated as medically necessary.

**ASSISTANT [REDACTED]:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

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

**PRE-OPERATIVE CLEARANCE:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

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

**MOTORIZED COLD THERAPY UNIT:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

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

**HOME NURSING FOR DAILY DRESSING FOR 2 WEEKS (X14 DAYS TOTAL):**

Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

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

**HOME PHYSICAL THERAPY 3X2:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

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

**BONE GROWTH STIMULATOR RENTAL AND FITTING:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

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

**POST OPERATIVE PHYSICAL THERAPY 2X6:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

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

**EMG/NCV BILATERAL UPPER EXTREMITIES WITH [REDACTED]:**  
Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

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