

<b>Case Number:</b>	CM13-0060684		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	01/01/2006
<b>Decision Date:</b>	06/09/2014	<b>UR Denial Date:</b>	11/06/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/03/2013

### 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 Spine Fellowship 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 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:

This is a 52 year old female patient s/p injury 10/1/89. The 10/1/13 progress note states that the patient has issues with neck and arm pain. She has right upper extremity pain and feels cold frequently. There is pain with extension of the neck. There is grossly normal motor strength. MRI cervical spine from 7/27/11 noted, at C4-5, a 2mm right lateral bridging osteophyte and hypertrophic change. At C6-7, there is evidence of a 2mm left sided bridging osteophyte with left paracentral disc protrusion. There is no central canal stenosis. There is solid fusion at C5-6. Diagnostic impression from the progress note was cervical radiculopathy with myofascial pain. A course of physical therapy and chiropractic therapy were recommended. The patient has been treated with medications and has had a previous cervical fusion at C5-6.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**ONE ANTERIOR CERVICAL DISCECTOMY DECOMPRESSION AND INSTRUMENTED FUSION, AUTOGRAFT, SYNTHETIC GRAFT, BONE MARROW ASPIRATION, ILIAC CREST BONE GRAFT, REVISION SPINAL SURGERY OF THE C4-5 AND C6-7 BETWEEN 10/16/2013 AND 2/2/2014: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 166, 179.

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

**Decision rationale:** CA MTUS criteria for cervical decompression include 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 electrophysiology evidence, consistently indicating the same lesion that has been shown to benefit from surgical repair both in the short and the long term, and unresolved radicular symptoms after receiving conservative treatment. The records reviewed do not contain adequate information to substantiate the medical necessity of the requested surgery. There are no recent imaging studies; with the MRI provided dating to 2011. There is no comprehensive clinical evaluation identifying correlating evidence of neurological compromise. The course of conservative care has not been described. It is unclear that non-surgical means have been exhausted. The medical necessity has not been established. Therefore the request is not medically necessary.

**TWO TO THREE NIGHT STAY AT [REDACTED] BETWEEN 10/16/2013 AND 2/3/2014:** 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.

**ONE ASSISTANT SURGEON BETWEEN 10/16/2013 AND 2/2/2014:** 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.

**ONE BONE STIM [REDACTED] BETWEEN 10/16/2013 AND 2/2/2014:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) LOW BACK CHAPTER, BONE GROWTH STIMULATOR.

**Decision rationale:** ODG criteria for bone growth stimulators include certain risk factors for failed fusion, such as multilevel fusion, smoking habit, or previous failed fusion. The associated request for cervical surgery has not been found to be medically necessary. The bone growth stimulator is not medically necessary.

**EIGHT AQUATIC THERAPY FOR THE CERVICAL SPINE ( [REDACTED] )  
BETWEEN 10/16/2013 AND 2/3/2014: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines AQUATIC THERAPY Page(s): 22.

**Decision rationale:** CA MTUS states that aquatic therapy is recommended as an optional form of exercise therapy, where available, as an alternative to land-based physical therapy when reduced weight bearing is indicated, such as with extreme obesity. There is no rationale justifying why this patient would need aquatic therapy as opposed to standard land based therapy. The request is not medically necessary.

**ONE PRE OP MEDICAL CLEARANCE BETWEEN 10/16/2013 AND 2/3/2014: 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.