

Case Number:	CM13-0063482		
Date Assigned:	12/30/2013	Date of Injury:	06/06/2000
Decision Date:	05/16/2014	UR Denial Date:	11/25/2013
Priority:	Standard	Application Received:	12/10/2013

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 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 43-year-old who was injured on June 6, 2000. The mechanism of injury is unknown. The patient's medications as of September 7, 2013 included Topamax, Treximet, Vicodin, and Prozac. Diagnostic studies reviewed include electromyography dated October 29, 2013 revealed no electroneurographic evidence of entrapment; neuropathy was seen in the lower extremities; and there were no indicators of acute lumbar radiculopathy. MRI of the cervical spine without contrast dated April 30, 2013 revealed 1) C6-7: A 3 mm disc bulge with diffuse osteophytic ridging mildly flattened the anterior thecal sac without compressing the cord; bilateral uncinat and facet hypertrophy moderate to severely narrow the neural foramen, similar to previous. 2) There was a 1 mm retrolisthesis and 2 mm diffuse bulging of the annulus at C5-6 which mildly flattens the anterior thecal sac without indenting the cord. This extends slightly more prominently into the lateral recesses bilaterally; disc bulge extending into the neural foramen with uncinat hypertrophy mildly narrowed the neural foramen bilaterally. 3) C3-4: There was a 1 mm disc bulge, and left facet hypertrophy without canal or foraminal stenosis. 4) There was a small focal syrinx at T1, unchanged in comparison to previous exam. Clinic note dated October 21, 2013 indicated the patient presented with complaints of continued symptomatology in the cervical spine, chronic headaches, tension between the shoulder blades and migraines. She had been diagnosed with multilevel cervical spondylosis. She had failed conservative measures up to this point in time which included activity modification, physical therapy, and pain management including failing three cervical epidural blocks. On physical examination of the cervical spine, there was paravertebral muscle spasm. She had a positive axial loading compression test. There was extension of symptomatology in the upper extremities in what appeared to be the C5 through C7 roots and dermatome. There was an extension of symptomatology into the bilateral shoulders and levator scapulae. The patient was diagnosed

with cervical discopathy. EST patient office visit dated September 7, 2013 reported the patient had complaints of migraines, neck injury and requesting more time off. On neurologic exam, deep tendon reflexes were intact. Physician's progress report dated April 30, 2013 stated the patient reported worsening of the cervical spine pain with associated worsening of her migraine headaches and has had one chiropractic treatment which had been beneficial. On examination, there was tenderness of the cervical spine with paravertebral and trapezius muscle. The range of motion flexion was to 30 degrees with 20 degrees right lateral bending; 30 degrees left lateral bending; 30 degrees right lateral rotation; 40 degrees left lateral rotation; and 20 degrees extension. There was a negative Spurling's, Adson, and Wright maneuver. She had increased pain with cervical motion. There was patchy, decreased sensation in the bilateral C6 distribution without motor weakness or reflex asymmetry. There was trace weakness of the right elbow flexion and supination. The patient was diagnosed with DDD (degenerative disc disease) of the cervical spine, cervical disc bulging C2-3, C5-6 and C6-7; right cervical radiculopathy and migraine headaches.

IMR ISSUES, DECISIONS AND RATIONALES

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

CK-C7, POSSIBLE C4-C5 ANTERIOR CERVICAL DISCECTOMY WITH IMPLANTATION OF HARDWARE: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 179-180.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) NECK, DISCECTOMY-LAMINECTOMY-LA Official Disability Guidelines (ODG), Neck Chapter, Discectomy-Laminectomy-Laminoplasty Section

Decision rationale: According to the ODG, decision for an anterior cervical discectomy at C5-C7, and possibly at C4-C5, with implantation of hardware is recommended as an option if there is a radiographically demonstrated abnormality to support clinical findings consistent with one of the following: (1) Progression of myelopathy or focal motor deficit; (2) Intractable radicular pain in the presence of documented clinical and radiographic findings; or (3) Presence of spinal instability when performed in conjunction with stabilization. The medical records document the patient diagnosed with cervical discopathy. The medical report dated October 21, 2013 document the patient had continued symptomolgy in the cervical spine with margarine; the patient had failed all the conservative measures including activity modification, physical therapy and pain management. On the physical examination there was par vertebral spasm \, positive axial loading compression test extetension of symptomolgy through the upper extremities to include C5-C7 dermatomes. There is an absence of documented physical examination that demonstrate sensory and motor deficit in the records provided. Further, the records failed to provide electrodiagnostic studies that correlate with the sings and the symptoms, and also the records failed to document the duration of the conservative treatment. The request for an anterior cervical discectomy at C5-C7, and possibly at C4-C5, with implantation of hardware is not medically necessary or appropriate.

2-3 DAY INPATIENT STAY AT [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 or appropriate.

[REDACTED] MINI COLLAR #1: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back (Acute & Chronic)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck Chapter, Collars (cervical) Section

Decision rationale: According to the ODG, Collar "cervical" is Not recommended for neck sprains Cervical collars are frequently used after surgical procedures and in the emergent setting following suspected trauma to the neck, where it is essential that an appropriately sized brace be selected that properly fits the patient. As the patient is not in postsurgical situation, therefore, the request is not medically necessary according to the guidelines. The request for a [REDACTED] Mini collar is not medically necessary or appropriate.

[REDACTED] J COLLAR WITH THORACIC EXTENSION #1: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back (Acute & Chronic)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck Chapter, Collars (cervical) Section

Decision rationale: According to the ODG, Collar "cervical" is Not recommended for neck sprains Cervical collars are frequently used after surgical procedures and in the emergent setting following suspected trauma to the neck, where it is essential that an appropriately sized brace be selected that properly fits the patient. As the patient is not in postsurgical situation, therefore, the request is not medically necessary according to the guidelines. The request for a [REDACTED] J collar with thoracic extensions is not medically necessary or appropriate.

BONE STIMULATOR: 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 or appropriate.

PRE-OP MEDICAL CLEARANCE WITH AN INTERNIST: 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 or appropriate.