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| Case Number: | CM13-0067957 | | |
| Date Assigned: | 01/03/2014 | Date of Injury: | 01/04/1991 |
| Decision Date: | 04/07/2014 | UR Denial Date: | 12/04/2013 |
| Priority: | Standard | Application Received: | 12/18/2013 |

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 Spine Surgery and is licensed to practice in New York. 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. 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 complains of chronic neck pain radiating to her shoulders and her arms. She also complains of weakness and numbness and tingling in the hands. She also has headaches. Physical examination demonstrates reduced cervical range of motion with cervical spasm. Spurling's test is positive. Weakness is reported in the deltoid, biceps, triceps, wrist extensors and flexors more the left than the right. Sensation is diminished in the C4 and C7 dermatomes more on the left. X-rays of the cervical spine show retrolisthesis at C4-5 and C5-C6. Cervical MRI shows small posterior disc protrusions from C342 C6-7 with the C5-6 foraminal and canal stenosis. At issue is whether three-level cervical ACDF surgery C4-C7 is medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

ANTERIOR CERVICAL DISCECTOMY AND FUSION WITH INSTRUMENTATION AT C4-C5, C5-C6 AND C6-C7: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Surgical Considerations and Occupational Medicine Practice Guidelines

Decision rationale: This patient has not been established criteria for three-level ACDF surgery. Specifically, the patient does not have documented instability in the cervical spine on radiographic imaging studies. Also, the patient does not have specific documented radiculopathy that correlates with specific compression on MRI imaging studies. The patient does not have documentation of myelopathy. There is no documentation of concern for tumor, fracture or instability. Established criteria for cervical spine fusion surgery are not met. Established criteria for cervical spine decompressive surgery are not met.

POST-OPERATIVE DME: CERVICAL COLLAR; BONE STIMULATOR; PRO-STIM UNIT, HOME CERVICAL TRACTION UNIT, PNEUMATIC CERVICAL TRACTION UNIT: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Surgical Considerations and Occupational Medicine Practice Guidelines

Decision rationale: Since this surgery is not medically needed, then all other associated items are not needed.

POST-OPERATIVE HOME HEALTH EVALUATION BY RN: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Surgical Considerations and Occupational Medicine Practice Guidelines

Decision rationale: Since this surgery is not medically needed, then all other associated items are not needed.

BILATERAL PRO WRIST SUPPORTS FOR CARPAL TUNNEL PAIN: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Surgical Considerations and Occupational Medicine Practice Guidelines

Decision rationale: Since this surgery is not medically needed, then all other associated items are not needed.