

<b>Case Number:</b>	CM14-0001952		
<b>Date Assigned:</b>	01/24/2014	<b>Date of Injury:</b>	03/31/1993
<b>Decision Date:</b>	06/19/2014	<b>UR Denial Date:</b>	12/24/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/07/2014

### 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 injured worker is a 65-year-old male who reported injury on 03/31/1993. The mechanism of injury was the injured worker was hit in the back of the neck during a riot in [REDACTED]. The injured worker underwent a lumbar laminectomy during that year. The injured worker had a decompression and fusion C3-T1 with instrumentation on 01/11/2013. The injured worker underwent epidural steroid injections at C4-5. The injured worker underwent an MRI of the cervical spine on 08/14/2013 which revealed myelomalacia was more pronounced in the lateral cervical cord dorsal to C4-5 but also with small foci present dorsally at the cord at this level bilaterally. There was a question of mild neural foraminal narrowing bilaterally at C7-T1 from uncinal joint spurs. Metal artifact obscured some details at that level. The most recent documentation was dated 10/10/2013. It indicated the Gabapentin at bedtime was not helpful; nerve root blocks were not helpful. The Vicodin did not help. The CT scan did not show a mass. Physical examination revealed weakness in the left C6 and right C7 myotomes and left EHL to manual muscle testing. The sensation was reduced bilaterally in the hands especially left greater than right thumb, index finger, left medial/lateral foot to pin prick and light touch. The reflexes were 1+ in the left biceps, trace to 1+ in the right triceps, 1 - 2+ in the left triceps, 2 - 3 in the right quadriceps, 1 - 2 in the left quadriceps and 1+ in the right gastric with a trace in the left gastrocnemius. The diagnoses included postlaminectomy syndrome of the cervical spine and cervical spondylosis with myelopathy as well as cervical spinal stenosis. The treatment plan included the injured worker should perform exercises in strengthening, have a refill of medications and it was opined that further surgery was complicated. The treatment plan additionally included spinal injections at the left L3-4. The injured worker underwent a CT of the cervical spine on 06/27/2013 which revealed mild to moderate central canal stenosis with mild to severe left lateral recess stenosis and mild bilateral neural foraminal stenosis at C5-6 secondary

to osteophytic spurring. There was mild to moderate left-sided neural foraminal stenosis at C2-3 secondary to uncovertebral hypertrophy and there was moderate bilateral neural foraminal stenosis at C3-4 and C4-5 secondary to osteophytic spurring and uncovertebral hypertrophy.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **REVISION CERVICAL WOUND: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 183.

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

**Decision rationale:** The ACOEM Guidelines indicate a surgical consultation is appropriate when there is clear clinical, imaging and electrophysiologic evidence consistently indicating the same lesion that has been shown to benefit from surgical repair in both the short and long term, there are unresolved radicular symptoms after receiving conservative treatment and activity limitation for more than 1 month or with extreme progression of symptoms. The clinical documentation submitted for review failed to provide documentation of the DWC Form RFA and PR2 to support the requested procedure. There was a lack of recent documentation indicating the injured worker had recent objective findings upon physical examination to support this surgical procedure. The level and laterality for the revision were not on the submitted request. Given the above, the request for revision of a cervical wound is not medically necessary.

#### **ONE DAY INPATIENT STAY: 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.

#### **PREOPERATIVE CLEARANCE WITH INTERNIST TO INCLUDE HISTORY AND PHYSICAL, LABS, EKG: 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.

