

Case Number:	CM14-0009313		
Date Assigned:	02/12/2014	Date of Injury:	10/16/2012
Decision Date:	08/14/2014	UR Denial Date:	12/30/2013
Priority:	Standard	Application Received:	01/24/2014

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 patient is a 48-year-old female with a 10/16/12 date of injury, when she attempted to lift a heavy package. A progress note from 11/12/13 described ongoing neck pain with bilateral upper extremity pain, greater on the left than right, as well as weakness of the left triceps and wrist extensors and reduced sensation to the long finger of the left hand. 10/23/13 note indicated that denial of the requested treatment would lead to prolonged disability and reduce likelihood for rehabilitation and achievement of highest level of function. It was noted that the patient has radicular arm pain and weakness for over a year and was noted on 12/6/12 that she has weakness of the left triceps and hand/finger extensor (1/5), with radiation down the entire arm. A C7 root compression was noted to be the predominant lesion. In addition, it was noted that findings for C6 and C7 compression frequently overlap, and is almost impossible to differentiate one from the other. A note from 11/6/12 indicated that there were abnormalities in EDS at C6 and C7. However, it was the physician's opinion that there was no C5 radiculopathy. In addition, it was noted that clinical findings may vary, day to day in intensity. A 10/31/13 MRI revealed a multilevel disc disease with congenitally short pedicles; mild central stenosis at C4-5 and C6-7; moderate central stenosis at C3-4. At C6-7, there was no evidence of significant central stenosis, but moderate to severe foraminal narrowing, right greater than left. Most recently, on 1/22/14, there was note of significant neck pain with radiation into the shoulders and down the right arm, high-grade stenosis at C6-7. The treating provider has requested Anterior C6-7 Cervical Discectomy and Fusion with Instrumentation, C6-7 Posterior Laminectomy, Hospital Stay, 3-4 Day, Intra-Operative Monitoring, and Post-Operative Purchase Hot/Cold Therapy Unit with Wrap.

IMR ISSUES, DECISIONS AND RATIONALES

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

ANTERIOR C6-7 CERVICAL DISCECTOMY AND FUSION WITH INSTRUMENTATION: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 179-182.

MAXIMUS guideline: The Expert Reviewer based his/her decision on the MTUS ACOEM Practice Guidelines, Chapter 8 Neck and Upper Back Complaints, page 180 and on the Non-MTUS Official Disability Guidelines (ODG) Neck and upper back chapter, discectomy-laminectomy-laminoplasty.

Decision rationale: The patient has a 2mm broad based spondylitic disc spur complex, marked bilateral uncovertebral hypertrophy; mild canal stenosis, and moderately severe bilateral foraminal stenosis at this level. She is significantly symptomatic with clinical evidence of muscle strength loss. In addition, there was noted failure of conservative treatment. 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. In addition, ODG states that anterior cervical fusion is recommended as an option in combination with anterior cervical discectomy for approved indications. As there is positive clinical evidence and corroborating imaging findings, as well as failure of conservative treatment, the request is substantiated. Medical necessity for the requested service is established. The requested service is medically necessary.

C6-7 POSTERIOR LAMINECTOMY: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 179-182.

MAXIMUS guideline: The Expert Reviewer based his/her decision on the MTUS ACOEM Practice Guidelines, Chapter 8 Neck and Upper Back Complaints, page 180 and on the Non-MTUS Official Disability Guidelines (ODG) Neck and upper back chapter.

Decision rationale: ACDF at C6-7 was found medically necessary due to positive clinical and imaging evidence. However, there is no justification for posterior approach. Anterior approach will adequately decompress the spinal nerves, and nothing on imaging indicates any significant posterior/dorsal compression. The request is not substantiated. Medical necessity for the requested service is not established. The requested service is not medically necessary.

HOSPITAL STAY, 3-4 DAY: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck Chapter, Hospital Length of Stay Guidelines.

MAXIMUS guideline: The Expert Reviewer based his/her decision on the Non-MTUS Official

Disability Guidelines (ODG) ODG hospital length of stay (LOS) guidelines: Cervical spine.

Decision rationale: Although ACDF was certified at one level, ODG supports up to 1 day inpatient stay following ACDF. The request cannot be modified and thus not found to be medically necessary.

INTRA-OPERATIVE MONITORING: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Intra-Operative neurophysiological monitoring.

MAXIMUS guideline: The Expert Reviewer based his/her decision on the Non-MTUS Official Disability Guidelines (ODG), Intraoperative neurophysiological monitoring.

Decision rationale: ACDF at C6-6 is found to be medically necessary and intraoperative neurophysiological monitoring is utilized in attempts to minimize neurological morbidity from operative manipulations. Medical necessity for the requested service is established. The requested service is medically necessary.

POST-OPERATIVE PURCHASE HOT/COLD THERAPY UNIT WITH WRAP: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck Chapter, Continuous-flow cryotherapy.

MAXIMUS guideline: The Expert Reviewer based his/her decision on the Non-MTUS Official Disability Guidelines (ODG), Continuous-flow cryotherapy.

Decision rationale: Medical necessity for the requested purchase of postoperative hot/cold therapy unit is not established. Although surgery was found medically necessary, guidelines only support 7-day postoperative use of cryotherapy units in order to reduce pain and necessity for postoperative medications. Combined units are not generally supported and purchase is not guideline recommended. Medical necessity for the requested item is not established. The requested item is not medically necessary.