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| <b>Case Number:</b>   | CM14-0019877 |                              |            |
| <b>Date Assigned:</b> | 04/30/2014   | <b>Date of Injury:</b>       | 04/14/2012 |
| <b>Decision Date:</b> | 07/15/2014   | <b>UR Denial Date:</b>       | 02/03/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 02/18/2014 |

### 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 Pennsylvania. 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 30-year-old gentleman who was injured in a work related accident on 04/14/12 sustaining an injury to the neck. Records include a recent MRI report of 11/11/13 showing the C5-6 level to be with a 2 mm disc protrusion with normal central canal and no neural foraminal narrowing. There was no evidence of compressive pathology at the C5-6 level. A follow up report of 12/04/13 with [REDACTED] stated continued complaints of pain about the neck, stating need for operative intervention to include a C5-6 anterior cervical discectomy and fusion. Physical examination was not performed at that date. Prior evaluation from 06/14/13 demonstrated a C6 sensory deficit to the upper extremities with diminished reflexes bilaterally. There is documentation of failed conservative care including epidural steroid injections, therapy, and medication management.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **ANTERIOR CERVICAL DISCECTOMY FUSION AT C5-6: 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).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 165 and 180.

**Decision rationale:** Based on California ACOEM Guidelines, the need for fusion at the C5-6 level would not be indicated. CA MTUS states, "The efficacy of cervical fusion for patients with chronic cervical pain without instability has not been demonstrated. Not Recommended: Discectomy or fusion for nonradiating pain or in absence of evidence of nerve root compromise." This individual's recent MRI scan from 11/2013 demonstrates no evidence of compressive pathology at the C5-6 level to support the need for operative procedure. The absence of clinical correlation with the claimant's imaging, would fail to support the surgical request in this case. The request is not medically necessary.

**ASSISTANT SURGEON:** 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.

**1-2 DAY IN PATIENT 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.

**PRE- OPERATIVE LABORATORY (COMPREHENSIVE METABOLIC PANEL ,PROTHROMBIN TIME ,PARTIAL THROMBOPLASTINE TIME, COMPLETE BLOOD PICTURE, URIC ACID, GLUCOSE IF DIABETIC ,CHEST X-RAY AND ELECTROCARDIOGRAM.):** 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.

**PER-OPERATIVE CLEARANCE WITH [REDACTED] IN HOUSE:** 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.

**POST-OPERATIVE VISITS AS PER HOSPITAL PROTOCOL:** 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.

**DURABLE MEDICAL EQUIPMENT LUMBER SACRAL OROTHOSIS:** 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.

**WALKER:** 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.

**COMMODE:** 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.

**OUT-PATIENT PHYSICAL THERAPY 2X4 FOR CERVICAL SPINE: 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.

**REGISTERED NURSE EVALUATION FOR WOUND CHECK: 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.

**HOME HEALTH AIDE SERVICES 2-3 TIMES A WEEK FOR FOUR WEEKS: 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.

**HOME POST OPERATIVE PHYSICAL THERAPY 2X4 FOR CERVICAL SPINE:  
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.