

Case Number:	CM14-0117839		
Date Assigned:	08/06/2014	Date of Injury:	03/04/2009
Decision Date:	09/10/2014	UR Denial Date:	07/07/2014
Priority:	Standard	Application Received:	07/25/2014

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 Neurological 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 57-year-old female who was reportedly injured on March 4, 2009. The mechanism of injury was not listed in these records reviewed. The most recent progress note dated June 10, 2014, indicated that there were ongoing complaints of neck pain with radiation into the left upper extremity. Also noted were complaints of low back pain. The physical examination demonstrated a normotensive, 160 pound individual who is in no apparent distress. There was decreased sensation noted in the left C6, C7 and C8 dermatomes. Spurling test was positive, and the patient has paravertebral muscle spasm and tenderness noted to palpation. There was tenderness in the low back, pain over the right L4-L5 and L5-S1 facet areas. Diagnostic imaging studies objectified a disc protrusion with posterior osteophytes at C6-C7 that exerted a mass effect of the ventral thecal sac. A 3mm disc protrusion was noted at C5-C6 also exerting a mass effect on the ventral thecal sac. Previous treatment included injection therapy, physical therapy, multiple medications and multiple pain management interventions. A request was made for cervical fusion surgery and was not certified in the pre-authorization process on July 7, 2014.

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 at C5-C6, C-6-C7: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 180-181, 183. Decision based on Non-MTUS Citation Official Disability Guidelines / Discectomy/laminectomy (excluding fractures): Official Disability

Guidelines / Neck and Upper Back (Acute & Chronic) Fusion, anterior cervical (Bertalanffy, 1988) (Savolainen, 1998) (Donaldson, 2002) (Rosenorn, 1983).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Cervical & Thoracic Spine disorders, surgical considerations-spinal fusion (electronically cited).

Decision rationale: As noted in the American College of Occupational and Environmental Medicine guidelines, spinal fusion in the cervical spine is recommended in patients with subacute or chronic radiculopathy due to ongoing nerve root compression. There is no elected diagnostic evidence of a verifiable radiculopathy noted in the progress notes presented for review. Also noted was a significant relief with facet joint injections indicated and an osteoarthritic situation. Furthermore, there is no significant motor deficit identified. No sensory deficits identified in either upper extremity and there are significant degenerative changes noted on imaging study. Therefore, when noting the data presented, and by the parameters noted in the American College of Occupational and Environmental Medicine guidelines, the medical necessity for this procedure has not been established.

Internal medicine pre-op clearance: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation In light of the recommendation for the non-certification of the requested surgical procedure, the request for the internal medicine pre-op clearance is also recommended non-certified.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Preoperative Evaluation Am Fam. Physician. 2000 Jul 15; 62 (2):387-396.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

RN assessment for post operative wound care: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation In light of the recommendation for the non-certification of the requested surgical procedure, the request for the RN assessment for post operative wound care is also recommended non-certified.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Home Health Services Page(s): 51 of 127.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

home aid as needed: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation In light of the recommendation for the non-certification of the requested surgical procedure, the request for the home aid as needed is also recommended non-certified.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Home Health Services Page(s): 51 of 127.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

12 post-op physical therapy sessions ([REDACTED]): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation In light of the recommendation for the non-certification of the requested surgical procedure, the request for the 12 post-op physical therapy sessions is also recommended non-certified.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Post-Surgical Treatment Guidelines California Code of Regulations, Title 8. Effective July 18, 2009. Displacement of cervical intervertebral disc (ICD9 722.0): Postsurgical treatment (discectomy/laminectomy): 16 visits over 8 weeks.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

University brace ([REDACTED]): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation In light of the recommendation for the non-certification of the requested surgical procedure, the request for the University brace is also recommended non-certified.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) cervical spine disorders (electronically cited).

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Bone growth stimulation unit ([REDACTED]): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation In light of the recommendation for the non-

certification of the requested surgical procedure, the request for the Bone growth stimulation unit is also recommended non-certified.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.