

Case Number:	CM14-0155403		
Date Assigned:	09/25/2014	Date of Injury:	10/09/2012
Decision Date:	11/25/2014	UR Denial Date:	08/25/2014
Priority:	Standard	Application Received:	09/23/2014

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:

This 57-year-old female sustained an industrial injury on 10/9/12 relative to a trip and fall onto her right side. Injuries were reported to the head, neck, and right shoulder, arm, wrist, and hand. The 5/20/13 cervical MRI impression documented a broad based central disc protrusion at C4/5 with mild central spinal canal stenosis. There was a broad-based disc protrusion at C5/6 impressing directly on the anterior aspect of the spinal cord and resulting in slight flattening. There was moderate central canal stenosis and moderate bilateral neuroforaminal narrowing due to disc osteophyte complex and bilateral facet arthropathy. There was a diffuse disc bulge at C6/7 with superimposed broad-based left paracentral disc protrusion with mild central canal stenosis, severe left neuroforaminal narrowing, and mild right neuroforaminal narrowing. The 3/4/14 bilateral upper extremity EMG/NCV impression documented a normal exam with no evidence of active cervical radiculopathy. The 3/4/14 cervical spine x-rays documented reversal of the cervical curve at C4/5 with degenerative disc changes at C5/6 and C6/7 with narrow disc space intervals and anterior osteophytes emanating from both these levels. There was loss of motion segmental integrity documented at the C4/5 spinal segment on flexion/extension views. The 6/27/14 spine surgery report cited constant grade 8-9/10 neck and right upper extremity pain associated with tingling and weakness in the right arm and hand, and numbness in the arms and feet. She reported having bladder problems. Symptoms were aggravated by stooping and prolonged standing, sitting and walking. Functional difficulty was noted in activities of daily living. Physical exam documented loss of normal cervical lordosis, paravertebral and cervical spinal muscle spasms and tenderness, and positive foraminal compression test. Passive range of motion was limited in all planes. Grip strength was diminished on the right. Right biceps and triceps weakness was noted. Deep tendon reflexes were hypoactive throughout. There was slight diminished sensation over the C6 distribution. The patient was diagnosed with cervical disc

herniations at C5/6 and C6/7 where there was flattening of the spinal cord with moderate to severe foraminal stenosis, and cervical radiculopathy. The patient had failed exhaustive treatment including medications, home exercise program, and physical therapy. The patient had significant pathology and MRI findings consistent with subjective and objective complaints of radiculopathy. Surgery was recommended in the form of an anterior cervical discectomy with instrumentation and fusion at C5/6 and C6/7. The 8/25/14 utilization review modified the surgery request and certified anterior cervical discectomy instrumentation fusion at C5/6 and C6/7 with pre-operative clearance, assistant surgery, and durable medical equipment (neck brace). The request for a 2 to 3 day inpatient stay was modified to 1 day consistent with guidelines. The request for 18 post-op physical therapy sessions was modification to an initial 12 visits consistent with guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

ASSOCIATED SURGICAL SERVICE: INPATIENT (2-3 DAYS): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Neck and Upper Back, Hospital length of stay (LOS)

Decision rationale: The California MTUS does not provide hospital length of stay recommendations. The Official Disability Guidelines recommend the median length of stay (LOS) based on type of surgery, or best practice target LOS for cases with no complications. The recommended median and best practice target for anterior cervical fusion is 1 day. The 8/25/14 utilization review modified the request for 2 to 3 days length of stay, certifying 1 day. There is no compelling reason to support the medical necessity beyond guideline recommendations and the 1 day hospital stay previously certified. Therefore, this request is not medically necessary.

ASSOCIATED SURGICAL SERVICE: POST-OP PT (3 X 6): Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 26.

Decision rationale: The California MTUS Post-Surgical Treatment Guidelines for cervical fusion suggest a general course of 24 post-operative visits over 16 weeks during the 6-month post-surgical treatment period. An initial course of therapy would be supported for one-half the general course or 12 visits. If it is determined that additional functional improvement can be accomplished after completion of the general course of therapy, physical medicine treatment may be continued up to the end of the postsurgical physical medicine period. The 8/25/14 utilization review recommended partial certification of 12 initial post-op physical therapy visits consistent with guidelines. There is no compelling reason submitted to support the medical

necessity of care beyond guideline recommendations and the care already certified. Therefore, this request is not medically necessary