

<b>Case Number:</b>	CM14-0161345		
<b>Date Assigned:</b>	10/06/2014	<b>Date of Injury:</b>	12/04/2013
<b>Decision Date:</b>	12/30/2014	<b>UR Denial Date:</b>	09/26/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/01/2014

### 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 is a 39 year old female with a 12/4/13 injury date. She was injured in a motor-vehicle accident while at work. X-rays of the cervical spine on 7/29/13 revealed straightening. A cervical MRI on 7/30/14 revealed a C5-6 broad-based central disc protrusion without cord edema, myomalacia, or canal stenosis. More recent cervical x-rays (7 views) on 9/9/14 demonstrated no significant abnormalities and no instability on the flexion and extension. In an 8/5/14 follow-up, the patient complained of continued neck pain. Objective findings included reduced cervical range of motion, full strength in the upper extremities throughout, and decreased sensation in the right C7-8 distribution. The plan included obtaining electrodiagnostic studies. In a 9/9/14 follow-up, the patient complained of continuous right-sided pain, indicating pain that radiates from her neck to her right upper extremity. There were no pertinent objective findings recorded. The provider recommended C5-6 anterior cervical discectomy and fusion (ACDF). Diagnostic impression: cervical radiculopathy. Treatment to date: medications, physical therapy, A UR decision on 9/26/14 denied the request for right C5-6 ACDF because there was no documentation of exam findings with objective radicular symptoms correlating to C5-6. In addition, there was no documentation of conservative care. The requests for EKG, CBC, serum HCG, and follow-up were denied because the associated surgical procedure was not certified.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Right Anterior C5-6 discectomy/fusion/instrumentation:** 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), Indications for Surgery, Discectomy/laminectomy (excluding fractures)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 180. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Neck and Upper Back Chapter--Anterior cervical fusion.

**Decision rationale:** 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. However, in this case there is a lack of documented objective exam findings to support a diagnosis of radiculopathy, and there is no rationale available that lends support to performing ACDF in the absence of radiculopathy. There is no evidence of nerve root impingement or cord compression on MRI, and no evidence of segmental instability on recent flexion/extension x-ray. It appears that part of the plan was to obtain electrodiagnostic studies, but these are not available. In addition, there is a lack of documentation of prior conservative treatment methods. The medical necessity of the procedure has not been established at this time. Therefore, the request for right anterior C5-6 discectomy/fusion/instrumentation is not medically necessary.

**EKG (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.

**Lab - CNC (complete blood count):** 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.

**Lab - Serum HCG (human chorionic gonadotropin):** 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.

**Follow-Up Clinic Visit in 30 days:** 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.