

Case Number:	CM14-0169644		
Date Assigned:	10/17/2014	Date of Injury:	08/21/2013
Decision Date:	11/20/2014	UR Denial Date:	10/02/2014
Priority:	Standard	Application Received:	10/14/2014

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:

According to the records made available for review, this is a 49-year-old male with a 8/21/13 date of injury. At the time (9/30/14) of request for authorization for C4-C5 and C6-C7 anterior cervical discectomy and fusion with iliac crest autograft, Associated surgical services: pre-operative labs: complete blood count (CBC), basic metabolic panel (BMP), prothrombin time (PT) and partial thromboplastin time (PTT), Associated surgical services: chest x-ray, Associated surgical services: electrocardiogram (EKG), Associated surgical services: urinalysis, and Associated surgical services: in-patient stay 1-2 days, there is documentation of subjective (neck pain associated with headaches and dizziness) and objective (tenderness over the right paracervical region, decreased range of motion, 5/5 motor strength, 2/4 upper extremities reflexes, and intact sensation) findings, imaging findings (reported MRI of the cervical spine (5/20/14) revealed a central disc protrusion at C6-7 which contacts the core and contributes to some mild narrowing of the canal and C4-5 disc demonstrates moderate disc degeneration with a posterior disc protrusion; report not available for review), current diagnoses (cervical sprain/strain and cervical spondylosis), and treatment to date (medications and acupuncture). Regarding anterior cervical decompression and fusion, there is no documentation of evidence of sensory symptoms in a cervical distribution that correlate with the involved cervical level; and an abnormal imaging (MRI) report with positive findings that correlate with nerve root involvement.

IMR ISSUES, DECISIONS AND RATIONALES

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

C4-C5 and C6-C7 anterior cervical discectomy and fusion with iliac crest autograft: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation ODG Neck and Upper Back: Discectomy-laminectomy-laminoplasty

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, Discectomy/laminectomy/laminoplasty; Fusion, anterior cervical

Decision rationale: MTUS reference to ACOEM guidelines identifies documentation of 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, as criteria necessary to support the medical necessity of cervical decompression. ODG identifies documentation of failure of at least a 6-8 week trial of conservative care, etiologies of pain such as metabolic sources (diabetes/thyroid disease) non-structural radiculopathies (inflammatory, malignant or motor neuron disease), and/or peripheral sources (carpal tunnel syndrome) should be addressed prior to cervical surgical procedures, evidence of sensory symptoms in a cervical distribution that correlate with the involved cervical level or presence of a positive Spurling test, evidence of motor deficit or reflex changes or positive EMG findings that correlate with the cervical level, an abnormal imaging (CT/myelogram and/or MRI) study with positive findings that correlate with nerve root involvement, as criteria necessary to support the medical necessity of cervical decompression. In addition, ODG identifies anterior cervical fusion is recommended as an option in combination with anterior cervical discectomy for approved indications. Within the medical information available for review, there is documentation of diagnoses of cervical sprain/strain and cervical spondylosis. In addition, there is documentation of failure of at least a 6-8 week trial of conservative care (medications and acupuncture). However, despite documentation of subjective (neck pain associated with headaches and dizziness) findings, and given documentation of objective (5/5 motor strength, 2/4 upper extremities reflexes, and intact sensation) findings, there is no documentation of severe, and disabling shoulder or arm symptoms (objective radicular findings in the requested levels). In addition, despite documentation of a medical report's reported imaging findings (central disc protrusion at C6-7 which contacts the cord and contributes to some mild narrowing of the canal and C4-5 disc demonstrates moderate disc degeneration with a posterior disc protrusion); there is no documentation of an abnormal imaging (MRI) report with positive findings that correlate with nerve root involvement. Therefore, based on guidelines and a review of the evidence, the request for C4-C5 and C6-C7 anterior cervical discectomy and fusion with iliac crest autograft is not medically necessary.

Associated surgical services: pre-operative labs: complete blood count (CBC), basic metabolic panel (BMP), prothrombin time (PT) and partial thromboplastin time (PTT): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Low Back

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.

Associated surgical services: chest x-ray: 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.

Associated surgical services: electrocardiogram (EKG): 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.

Associated surgical services: urinalysis: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Low Back

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.

Associated surgical services: in-patient stay 1-2 days: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Neck and Upper Back

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.