

<b>Case Number:</b>	CM14-0178154		
<b>Date Assigned:</b>	10/31/2014	<b>Date of Injury:</b>	10/31/2003
<b>Decision Date:</b>	12/08/2014	<b>UR Denial Date:</b>	10/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/27/2014

### 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 Spine Surgery and is licensed to practice in Texas. 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 61-year-old male who reported injury on 10/31/2003. The mechanism of injury was the injured worker was throwing chunks of asphalt weighing approximately 25 pounds onto the street and experienced left shoulder pain. The medications were not provided. The prior treatments included epidural steroid injections. The surgical interventions included an arthroscopic rotator cuff repair on 02/16/2004, and the injured worker underwent further surgical intervention in 2005. The injured worker underwent a CT of the cervical spine on 10/02/2013 which revealed, at the level of C5-6, there was a moderate marginal osteophyte formation predominantly. There was normal alignment. The documentation of 09/08/2014 revealed the injured worker had complaints of bilateral shoulder pain, elbow pain, and right forearm pain, as well as right wrist and hand pain and cervical spine pain. The physician documented they had results of an MRI of the cervical spine. The documentation indicated the injured worker underwent an MRI of the cervical spine on 05/29/2014, which revealed a 3 mm far right posterolateral disc protrusion at C5-6 resulting in severe right C5-6 foraminal stenosis. There was potential for impingement on the exiting right C6 nerve. The diagnoses included cervical disc herniation with radiculitis and radiculopathy status post epidural steroid injection x3, and the treatment plan included an anterior cervical discectomy and fusion at C5-6. There was no Request for Authorization submitted for review. The injured worker underwent a nerve conduction study on 06/03/2014, which revealed a suggestion of a possible chronic bilateral C7 or C6 radiculopathy.

### 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 C5-6: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 180-181.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 179-181.

**Decision rationale:** The American College of Occupational and Environmental Medicine indicates that a surgical consultation may be appropriate for patients who have activity limitation for more than 1 month or with extreme progression of symptoms. There should be documentation of clear clinical, imaging, and electrophysiological evidence consistently indicating the same lesion that has been shown to benefit from surgical repair in both the short and long term. There should be documentation of unresolved radicular symptoms after receiving conservative treatment. The efficacy of cervical fusion for patients with chronic cervical pain without instability has not been demonstrated. The clinical documentation submitted for review failed to provide objective findings to support a necessity for discectomy and fusion at C5-6. The electrodiagnostic studies indicated there was a possibility of C6 radiculopathy. The MRI that was mentioned for the date of 05/29/2014 was not provided for review. There was a lack of documentation indicating the conservative care that was previously utilized. There was a lack of documentation of exceptional factors to warrant nonadherence to guideline recommendations. Given the above, the request for Anterior Cervical Discectomy and Fusion at C5-6 is not medically necessary.

### **Hospital Stay 2-3 days: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 180-181.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** As the requested surgical intervention is not supported by the documentation, the requested ancillary service is also not supported.

### **Hot cold unit: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 180-181.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** As the requested surgical intervention is not supported by the documentation, the requested ancillary service is also not supported.

### **Soft cervical collar: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 180-181.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** As the requested surgical intervention is not supported by the documentation, the requested ancillary service is also not supported.

**DVT Compression:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 180-181.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** As the requested surgical intervention is not supported by the documentation, the requested ancillary service is also not supported.

**Bone growth stimulator:**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 180-181.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** As the requested surgical intervention is not supported by the documentation, the requested ancillary service is also not supported.