

<b>Case Number:</b>	CM14-0083537		
<b>Date Assigned:</b>	07/21/2014	<b>Date of Injury:</b>	02/08/2001
<b>Decision Date:</b>	09/12/2014	<b>UR Denial Date:</b>	05/20/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/05/2014

### 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 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 66-year-old male who reported an injury on 02/08/2001. The mechanism of injury was not specifically stated. The current diagnoses include chronic neck pain with right upper extremity radiculopathy, status post anterior interbody fusion of the cervical spine, status post bilateral ulnar neuropathy surgery, status post carpal tunnel release, status post bilateral trigger finger release, diabetes, hypertension, and status post gastric bypass surgery. Previous conservative treatment includes physical therapy and pain medication. The injured worker was evaluated on 04/22/2014 with complaints of persistent cervical spine and upper extremity pain. The injured worker was status post 2 level surgery at C5-6 and C6-7 in 2004. The current medication regimen includes Vicodin and Norco. Physical examination on that date revealed a well healed anterior scar in the cervical spine, limited cervical range of motion, negative Spurling's and Lhermitte's sign, bilateral weakness in the intrinsic hand muscles, absent upper and lower extremity stretch reflexes, atrophy in the intrinsic muscle groups bilaterally, and hypoesthesia overall 5 fingers bilaterally. Treatment recommendations at that time included an anterior interbody fusion at C4-5 with removal of hardware at C5-6 and C6-7. It is noted that the injured worker underwent an MRI of the cervical spine on 01/07/2013 which indicated a stable appearance of the cervical spine status post C5 through C7 anterior cervical fusion with spinal stenosis at C4-5.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**C4-5 Anterior Cervical Discectomy and Interbody Fusion with C5-6 and C6-7 Anterior Instrumentation Removal: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 179-180. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck & Upper Back Chapter, Fusion, Anterior Cervical.

**Decision rationale:** California MTUS/ACOEM Practice Guidelines state a referral for surgical consultation is indicated for patients who have persistent and severe shoulder or arm symptoms, activity limitation for more than 1 month, clear clinical, imaging and electrophysiological evidence of a lesion, and unresolved radicular symptoms after receiving conservative treatment. The Official Disability Guidelines state a cervical fusion is indicated for acute traumatic spinal injury, osteomyelitis, primary or metastatic bone tumor, cervical nerve root compression, spondylotic myelopathy, or spondylotic radiculopathy. There should be evidence of persistent or progressive radicular pain or weakness and a failure of conservative treatment. As per the documentation submitted, the injured worker does demonstrate limited cervical range of motion with weakness, atrophy, and hypoesthesia in the upper extremities. However, there is no documentation of an exhaustion of conservative treatment prior to the request for an additional cervical spine procedure. There is no evidence of spinal instability upon flexion and extension view radiographs. Therefore, the injured worker does not currently meet criteria for the requested procedure. As such, the request is not medically necessary.

**Assistant Surgeon:** Upheld

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

**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.

**Pre-operative Labs:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

**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.

**EKG:** Upheld

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

**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.

**Chest X Rays:** Upheld

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

**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.

**Bone Growth Stimulator:** Upheld

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

**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.

**Cervical Collar:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

**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.

**1 Day In-Patient Stay:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

**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.