

<b>Case Number:</b>	CM14-0092449		
<b>Date Assigned:</b>	08/06/2014	<b>Date of Injury:</b>	12/08/2010
<b>Decision Date:</b>	09/12/2014	<b>UR Denial Date:</b>	06/06/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/18/2014

### 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 Anesthesiology, has a subspecialty in Pain Medicine, 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:

The injured worker is a 63 year old male who sustained an injury on 12/08/10 when he was attempting to carry a heavy object and slipped and fell injuring his neck. Prior treatment included an extensive amount of chiropractic therapy. The injured worker also attended physical therapy without benefit. It is noted the injured worker has had a prior cervical fusion from C3 to C7 performed in 2012. No other recent treatment to include medications or injections was documented. The injured worker did have a computed tomography (CT) study of the cervical spine completed on 01/15/14 which noted a prior fusion from C3 to C7 with anterior plating and screws, no hardware complications were noted and there appeared to be a solid fusion through the construct, some facet hypertrophy at C5 to C6 and at C6 to C7 contributing to mild foraminal stenosis bilaterally, no significant central canal stenosis was noted at C7 to T1, and no complications of the hardware. The injured worker was seen on 05/02/14 with continuing complaints of neck pain radiating to the upper extremities with associated numbness, tingling, and weakness. Physical examination noted tenderness to palpation in the paraspinal region of the cervical spine with limited cervical range of motion. Foraminal compression testing was negative. There was decreased sensation mild in severity from C4 to C7 bilaterally. Reflexes were trace in the upper extremities. Mild weakness was noted throughout the upper extremities. The injured worker was recommended for further revision surgery at C6 to C7 to include anterior and posterior discectomy and fusion, removal of an anterior cervical plate, removal of a large bridging osteophyte anterior at C7 to T1, followed by posterior lateral mass screw fixation at C6 to C7 with laminoforaminotomy and resection of bony hyperostosis to the left at C5 to C6 and bilaterally at C6 to C7. This request was denied by utilization review on 06/04/14 as well as the requested preoperative surgical clearance, postoperative cervical collar, bone growth stimulator, home health care two weeks, postoperative physical therapy for eighteen to twenty four sessions,

MRI studies of the cervical spine, assistant surgeon, a two day hospital stay, preoperative laboratory work, and chest ray as well as electrocardiogram (EKG).

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Revision Anterior and posterior cervical discectomy and fusion at C6-7 with removal of prior anterior cervical plate with placement of new plate, removal of large bridging anterior osteophyte at C7-T1, and posterior spinal lateral mass screw fixation at C6-7 with bilateral laminoforaminotomy and res: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

**Decision rationale:** In review of the CT studies of the cervical spine, there was no clear evidence of any pathology that would reasonably require the requested surgical procedures. Furthermore, the injured worker's physical examination findings are consistent with residual upper extremity radiculopathy that would be expected given the injured worker's prior cervical fusion procedures. Given the absence of any clear imaging evidence for the procedures as well as the lack of documentation regarding any recent medication use or injections, this request is not recommended as medically necessary.

**Pre operative internal medicine consult for surgical clearance: Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Pre-operative testing, general.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Post operative cervical collar: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck & Upper Back Chapter, Cervical Collar, Post-operative.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Post operative bone stimulator:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck & Upper Back Chapter, bone growth stimulator.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Home health care for two weeks.:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Home health services.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck & Upper Back Chapter, Home Health Care.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**post operative physical therapy for 18-24 sessions (Cervical Spine):** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 23.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**MRI scan Cervical Spine.:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 179-180.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 176.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Assistant surgeon:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: American Association of Orthopaedics Surgeons Position Statement Reimbursement of the First Assistant at Surgery in Orthopaedics.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**2 day hospital stay.:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck & Upper Back Chapter, Hospitalization.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Preoperative lab work:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Pre-operative testing, general.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Chest X-Ray and EKG.:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Pre-operative testing, general.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.