

Case Number:	CM14-0094910		
Date Assigned:	07/25/2014	Date of Injury:	11/19/2010
Decision Date:	11/18/2014	UR Denial Date:	06/10/2014
Priority:	Standard	Application Received:	06/20/2014

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 Physical Medicine and Rehabilitation 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 54-year-old male who sustained an injury on 11/19/10. As per the report of 04/08/14, he developed difficulty swallowing secondary to anterior cervical discectomy and fusion was performed on 02/01/12. The patient was able to eat foods and drink liquids; however, the routine process of swallowing saliva was difficult. At times, he felt that his throat was closing and developed anxiety. He had changes in his voice and tightness in his throat with vocalization. He suffered from vocal fatigue and neck discomfort after conversation. It was unclear whether removing the hardware would improve his symptoms. On exam he had some mild protrusion of the posterior pharyngeal wall and deviated nasal septum on left. Flexible fiberoptic laryngoscopy done on 04/08/14 revealed that posterior pharyngeal wall had abnormal slight protrusion with cobblestoning. Barium swallow dated 04/24/14 revealed normal protocol swallow. Videofluoroscopic swallow evaluation dated 04/24/14 indicated dysphagia, pharyngeal phase. Electrodiagnostic report dated 05/08/14 revealed chronic moderately to severe right C5-6 radiculopathy. He underwent C-spine surgery on 02/01/12 and right shoulder ORIF on 08/30/13. Current medications include omeprazole, Prilosec and Tylenol with Codeine. Past treatments have included pain medications, PT and ESI. Diagnoses include never a smoker; dysphagia pharyngeal; laryngopharyngeal reflux; vocal fatigue; and C-spine disease. The request for video-laryngoscopy with stroboscopy was denied on 06/10/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Vidoelaryngoscopy with stroboscopy: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Sercarz J A, Berke GS, Ming Y, et al. Videostroboscopy of human vocal fold paralysis, *Rhinol Laryngol.* 1992; 101 (7): 567-577

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:

Decision rationale: CA MTUS/ACOEM/ODG do not address the issue. Therefore, [REDACTED] was consulted: Video laryngoscopy is a form of indirect laryngoscopy in which the clinician does not directly view the larynx. Instead, visualization of the larynx is performed with a fiberoptic or digital laryngoscope inserted transnasally or transorally. Any patient who meets the criteria for intubation can be intubated fiberoptically. However, because of the equipment involved, most clinicians reserve fiberoptic intubation for patients who have a difficult airway. Patients with the following conditions or in the following categories are likely to have a difficult airway: Micrognathia, Mandibular fracture, Partially obstructing laryngeal lesions such as papilloma or supraglottitis, A necessity for awake intubation, Cervical spine injuries or cervical instability, Rheumatoid arthritis (or patients unable to extend the neck), A history of head and neck radiation, Trismus, Craniofacial abnormalities. In this case, the medical records do not mention any of the indications for videolarngoscopy. Furthermore, the IW had Videofluoroscopic swallow evaluation dated 04/24/14 which revealed dysphagia with pharyngeal phase. Therefore, based on guidelines and a review of the evidence, the request is not medically necessary.