

<b>Case Number:</b>	CM14-0138692		
<b>Date Assigned:</b>	09/05/2014	<b>Date of Injury:</b>	04/16/2014
<b>Decision Date:</b>	01/09/2015	<b>UR Denial Date:</b>	08/20/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/27/2014

### 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 Surgeon 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 35-year-old male who reported an injury on 04/16/2014. The mechanism of injury was while the injured worker was pulling a glass coffee table and strained his upper back and neck. His diagnoses included cervical spine sprain, thoracic spine sprain, cervical myelopathy, and herniated nucleus pulposus at C5-6 with radiculopathy. The previous treatment included medication and physical therapy. Diagnostic testing included an MRI dated 07/16/2014, which revealed a 2 mm disc protrusion at C5-6 and no spinal stenosis, foraminal narrowing, or neural compression. On 08/13/2014, it was reported the injured worker complained of pain which was worse and not tolerable. He rated his pain 9/10 in severity without medication and 5/10 in severity with medication. He complained of severe pain in his neck radiating into his arms with weakness, numbness, and tingling in the bilateral upper extremities, worse on the left. The injured worker complained of dropping items. On the physical examination, the provider noted the injured worker to have normal reflex, sensory, and power testing in the bilateral upper extremities and lower extremities, except for weakness noted to be 4/5 and numbness on the left at C6, as well as hyperreflexia at both knees and ankles. The provider noted the injured worker to have positive cervical tenderness and muscle spasms in the paraspinal musculature. The cervical spine range of motion was decreased by 40%. The provider noted a positive Spurling's sign on the left. A request was submitted for an anterior cervical decompression and instrumented fusion at C5-6 level with allograft bone, interbody cage, and anterior cervical plating, an assistant surgeon, hot/cold unit, muscle stimulator unit, cervical collar, Celebrex, and Neurontin for significant pain which was not improved with conservative therapy. The Request for Authorization was submitted and dated 08/14/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Anterior cervical decompression and instrumented fusion at C5-6 level with allograft bone, interbody cage and anterior cervical plating:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 179-181. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) neck & Upper Back, Fusion, anterior cervical

**Decision rationale:** The California MTUS/ACOEM Guidelines state surgical consultation is indicated for those with persistent severe and disabling shoulder or arm symptoms, activity limitation for more than 1 month, and clear clinical, imaging, and electrophysiological evidence consistently indicating the same lesion that has been shown to benefit from the surgical repair in both the short and long term. In addition, the Official Disability Guidelines note, for anterior cervical fusion, recommendations include acute traumatic spinal injury resulting in cervical spine instability, osteomyelitis resulting in vertebral body destruction, cervical nerve root compression verified by diagnostic imaging including an MRI or CT myelogram resulting in severe pain or profound weakness of the extremities, persistent or progressive radicular pain or weakness secondary to nerve root compression or moderate or severe neck pain despite 8 weeks of conservative therapy, significant clinical findings of functional limitations, resulting in inability or significant decreased ability to perform normal daily activities, and repeat surgery is not recommended at the same level. The imaging studies submitted lack findings of nerve root compression, spinal stenosis, foraminal narrowing. There is a lack of significant documentation indicating the provider suspected the injured worker to have osteomyelitis resulting in vertebral body destruction. There is a lack of significant documentation of cervical spinal instability. Therefore, the request is not medically necessary.

**Assistant Surgeon:** 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.

**Hot/Cold unit:** 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.

**Muscle Stimulator unit:** 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.

**Cervical Collars:** 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.

**Celebrex 200mg #30:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 67-68.

**Decision rationale:** The California MTUS Guidelines recommend nonsteroidal anti-inflammatory drugs at the lowest dose for the shortest period of time. The guidelines note NSAIDs are recommended for the signs and symptoms of osteoarthritis. There is a lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request as submitted failed to provide the frequency of the medication. Additionally, the guidelines recommend NSAIDs for the shortest period of time. The injured worker has been utilizing the medication for an extended period of time. Therefore, the request is not medically necessary.

**Neurontin 800mg #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy Drugs (AEDS) Page(s): 16.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
Gabapentin Page(s): 49.

**Decision rationale:** The California MTUS Guidelines state Gabapentin has been shown to be effective for the treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first line treatment for neuropathic pain. There is a lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. Therefore, the request is not medically necessary.