

Case Number:	CM14-0168639		
Date Assigned:	10/16/2014	Date of Injury:	02/16/2012
Decision Date:	01/05/2015	UR Denial Date:	09/26/2014
Priority:	Standard	Application Received:	10/13/2014

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 Georgia South Carolina. 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 58-year-old male who reported an injury on 02/16/2012. The mechanism of injury was not submitted within the submitted medical records. The injured worker's diagnoses included chronic pain, degenerative cervical intervertebral disc, cervicgia, neuralgia, neuritis/radiculitis, myofascial pain. Previous forms of therapy included injection therapy, physical therapy, acupuncture therapy, and medications. Medications were noted to include Orphenadrine, Tramadol, and Terocin patches. Diagnostic studies included an official MRI of the cervical spine completed on 09/12/2014, read by [REDACTED] which documented at C3-4 loss of disc height with mild left sided facet arthropathy, at C4-5 a loss of disc height with a moderate to severe degree of left foraminal stenosis and mild right foraminal stenosis, at C5-6 a loss of disc height with a trace central protrusion and mild to moderate left foraminal stenosis, at C6-7 a loss of disc height with mild central stenosis and severe bilateral foraminal stenosis. There is also an official electrodiagnostic study conducted on 10/15/2014, read by [REDACTED] which documented moderate cervical radiculopathy on the left side of C6-7, as well as ulnar nerve entrapment of the elbow. The clinical visit on 09/03/2014 documented that the injured worker was complaining of left elbow pain with posterior neck pain and neck spasms. The physical exam noted tenderness to palpation with muscle twitch response in the bilateral trapezius and levator scapulae. It was also noted the injured worker had a full painless range of motion of the neck with normal stability along with normal strength and tone. Motor strength in the left upper extremity was rated 4/5. In the right upper extremity, muscle testing was rated 5/5. There were noted hyperesthesia's to pinprick over the left ulnar with hyperesthesia's to touch and pressure over the left ulnar. Deep tendon reflexes were listed as normal and symmetrical with a noted positive Tinel's of the left ulnar nerve and mildly positive at the left scalene muscles. The Request for Authorization was not provided within the medical records.

IMR ISSUES, DECISIONS AND RATIONALES

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

Associated surgical service: C4-C7 and possibly C3-C4 anterior cervical microdiscectomy with implantation of hardware and realignment of the junctional kyphotic deformity:

Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 183. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Workers Compensation (TWC), Neck and Upper Back Procedure Summary last updated 08/04/2014, Criteria for Anterior Cervical Discectomy and Fusion

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back (Acute & Chronic), Discectomy-laminectomy-laminoplasty & Fusion, anterior cervical

Decision rationale: The request for associated surgical service: C4-C7 and possibly C3-C4 anterior cervical microdiscectomy with implantation of hardware and realignment of the junctional kyphotic deformity is not medically necessary. The indications for surgical intervention for discectomy by the Official Disability Guidelines state that there must be evidence of radicular pain and sensory symptoms in a cervical distribution that correlate with the involved cervical level or presence of a positive Spurling's test. There should also be evidence of motor deficit or reflex changes or positive EMG findings to correlate with the cervical levels being requested. It is also noted that there should be abnormal imaging studies to show positive findings that correlate with nerve root involvement that is found with the previous objective physical and/or diagnostic findings. There should also be documentation that the injured worker has failed a 6 to 8 week trial of conservative care. For indications of fusion, the guidelines state that there should be cervical nerve root compression verified by diagnostic imaging and resulting in severe or profound weakness of the extremities. When requesting authorization for cervical fusion of multiple levels, each level is subject to the criteria outlined in the guidelines. Fewer levels are preferred to limit the strain on the unfused segments. Within the submitted medical records, the injured worker had confirmatory electrodiagnostic studies to show that there was only 1 level that presented with radiculopathy. The other remaining levels did not show signs of radiculopathy through electrodiagnostic testing. Moreover, the physical exam findings did not show that the injured worker had correlating radiculopathy at the requested levels. Lastly, there is no documentation of the injured worker having recent failure of conservative therapies for the cervical spine. Without further documentation to address the aforementioned deficiencies outlined in the review, the request at this time is not supported by the guidelines. As such, the request is not medically necessary.

Associated surgical service: Bone stimulator purchase: 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.

Associated surgical service: Miami J collar with thoracic extension purchase, QTY: 1:
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.

Associated surgical service: Minerva mini collar purchase, QTY: 1: 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.

Associated surgical service: Medical clearance with an internist: 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.

Associated surgical service: Hospital inpatient stay, QTY: 2-3 days: 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.

