

Case Number:	CM14-0201238		
Date Assigned:	12/12/2014	Date of Injury:	10/20/2011
Decision Date:	01/31/2015	UR Denial Date:	11/20/2014
Priority:	Standard	Application Received:	12/01/2014

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, has a subspecialty in Spine Surgeon and is licensed to practice in New Jersey. 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 female who reported an injury on 10/20/2011. The mechanism of injury was cumulative trauma. Her diagnoses include neck pain, cervical spondylosis with radiculopathy, and cervical disc herniation. Her past treatments include chiropractic, cervical epidural steroid injections, physical therapy, cervical facet injections, a cervical radiofrequency at the left C5-7 and medications. Diagnostic studies include cervical x-rays, electrodiagnostic studies, an official cervical MRI, performed on 09/24/2014, with findings of worsening anterolisthesis of C4/C5; facet arthropathy was seen on the left at this level. Severe left neural foraminal stenosis at C6-7. There is also moderate to severe left neural foraminal stenosis at C4-5. Disc disease at C5-6, C6-7, and C7-T1 is stable. Her surgical history was noncontributory. On 11/10/2014, the injured worker presented with complaints of neck pain with numbness in her wrists and hands. Upon physical examination of the cervical area, sensation at the left C7 was noted to be diminished. She was noted to have decreased range of motion upon extension and pain with lateral rotation bilaterally. Left finger flexors and extensors were weak at a 4/5. There was pain with resistance testing in the left shoulder upon abduction and weakness to a 4/5. Clonus, Hoffman's, Babinski's were all noted to be absent bilaterally. Her current medication regimen was not provided within the submitted documentation. The treatment plan included an anterior cervical discectomy and fusion with allograft and plate at the C4-5 and C5-6 levels. The rationale for the request was that she has tried and failed conservative therapy. Additionally, she has tried cervical epidural steroid injections, facet joint injections, and rhizotomy without significant benefit, and continues to have complaints of neck pain with tingling/numbness in the left hand, which has progressed to all of her fingers, except the thumb. A Request for Authorization form, dated 11/13/2014, was provided within the submitted documentation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Pre-surgical type and screen 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 base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back (Acute & Chronic), Preoperative lab testing

Decision rationale: The request for pre-surgical type and screen is not medically necessary. The injured worker has cervical pain radiating into her upper extremities. The Official Disability Guidelines state the decision to order preoperative tests should be guided by the patient's clinical history, comorbidities, and physical examination findings. Preoperative routine tests are appropriate if patients with abnormal tests will have a preoperative modified approach. A complete blood count is indicated for patients with diseases that increase the risk of anemia or patients in whom significant perioperative blood loss is anticipated. Coagulation studies are reserved for patients with a history of bleeding or medical conditions that predispose them to bleeding, and for those taking anticoagulants. The injured worker presented on 11/10/2014 with complaints of continued cervical pain. Documentation submitted for review did not give any indication of the injured worker being at any increased risk requiring the need for pre-surgical type and screen. In the absence of the aforementioned documentation, the request as submitted does not support the evidence based guidelines. As such, the request for pre-surgical type and screen is not medically necessary.

In-patient hospital stay QTY: 3.00 (days): Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 180-181. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck & Upper Back Complaints, Hospital Length of Stay

Decision rationale: The request for in-patient hospital stay (in days) for 3 days is not medically necessary. The injured worker has chronic cervical pain with radiculopathy. The injured worker has tried and failed conservative therapy. The Official Disability Guidelines recommend 1 hospital day stay for an anterior cervical fusion. The request as submitted exceeds the guideline recommendations. The request as submitted does not support the evidence based guidelines. As such, the request for In-patient hospital stay (in days) for 3 days is not medically necessary.

