

Case Number:	CM14-0208818		
Date Assigned:	12/22/2014	Date of Injury:	06/29/2006
Decision Date:	02/25/2015	UR Denial Date:	11/13/2014
Priority:	Standard	Application Received:	12/12/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: Texas
Certification(s)/Specialty: Orthopedic Surgery

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 patient is a 47-year-old male who reported an injury on 06/29/2006. The mechanism of injury was a fall. On 10/20/2014, the patient presented with continued neck and radicular arm pain in the upper extremities bilaterally. Medications include Prozac, Prilosec, metoprolol, and Lovastatin. Upon examination, the patient had a negative Spurling's maneuver to the cervical spine, intact sensation to light touch. The diagnosis was cervical herniated nucleus pulposus. The provider noted that the patient had failed all forms of conservative treatment. The provider recommended a C3-6 anterior cervical discectomy and fusion. The Request for Authorization form was dated 11/07/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

C3-C6 Anterior Cervical Discectomy Fusion: 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, Indications for Surgery, Neck & upper Back Chapter, Fusion, Anterior Cervical

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, Fusion, anterior cervical

Decision rationale: The request for a C3-C6 anterior cervical discectomy fusion is not medically necessary. Official Disability Guidelines recommend an anterior cervical fusion as an option in combination with an anterior cervical discectomy for approved indications. Criteria for a cervical fusion included acute trauma or spinal injury, osteomyelitis resulting in vertebral body destruction, metastatic bone tumor, spondylotic myelopathy based on clinical signs or symptoms, spondylotic radiculopathy or non-traumatic instability that includes significant symptoms that correlate with physical exam findings, radiologist interpreted imaging reports. There should be persistent or progressive radicular symptoms or weakness secondary to nerve root compression or moderate to severe neck pain despite 8 weeks of conservative therapy with at least management of oral steroids or epidural steroid injections, physical therapy, active pain management, clinical means of significant limitations on physical exam that result in instability or significantly decreased ability to perform normal activities of daily living, along with positive imaging findings of nerve root compression. The clinical documentation submitted for review noted that the patient had a negative Spurling's test. There was no evidence of radicular symptoms specific to the C3 to C6 dermatomes. There is no evidence of positive imaging studies that correlate instability. There is no evidence that the patient had tried and failed an adequate course of conservative therapy to include physical therapy, injections, and medications. As such, medical necessity has not been established. Therefore, this request is not medically necessary.

Associated Surgical Service: 3 Day Inpatient Hospital Stay: 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.