MAXIMUS Federal Services

Case Number:	CM15-0106907		
Date Assigned:	06/15/2015	Date of Injury:	01/05/2011
Decision Date:	07/14/2015	UR Denial Date:	05/18/2015
Priority:	Standard	Application Received:	06/03/2015

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: New York
Certification(s)/Specialty: Neurological 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 injured worker is a 53-year-old male, who sustained an industrial injury on 1/5/11. He has reported initial complaints of neck and right shoulder injury. The diagnoses have included neck pain, multi-level discopathy, most significant at C6-7, and right carpal tunnel syndrome. Treatment to date has included medications, activity modifications, off work, diagnostics, physical therapy, acupuncture, shoulder injections, and other modalities. Currently, as per the physician progress note dated 4/13/15, the injured worker complains of neck pain with stiffness and right upper extremity radicular complaints. He rates the pain 7-9/10 on pain scale and is associated with pain and numbness that radiates down the right arm. He also has right shoulder pain and right carpal tunnel syndrome. The physical exam of the cervical spine reveals that there is moderately limited range of motion, slow and guarding with pain noted. Spurling's sign is positive bilaterally. There is anterior deltoid trace weakness on the right and sensory findings include hypesthesia. The diagnostic testing that was performed included Magnetic Resonance Imaging (MRI) of the neck spine dated 9/8/14 reveals multi-level degenerative changes with active degenerative disc disease (DDD) most pronounced at C6-7 and degenerative joint arthrosis causing severe neural foraminal narrowing. The electromyography (EMG)/nerve conduction velocity studies (NCV) dated 9/29/14 of the right upper extremity reveals evidence of moderate to severe right carpal tunnel syndrome. The current medications included Meloxicam, Amitriptyline, Celebrex and Vicodin. The previous therapy sessions were not noted in the records. The physician requested treatments included Right carpal tunnel release, C6-7 Anterior Cervical Discectomy and Fusion (ACDF), Preoperative labs: Complete Blood Count (CBC), Comprehensive Metabolic Panel (CPM), Prothrombin Time (PT) and International Normalized Ratio (INR), Assistant surgeon, and Associated surgical service: Inpatient hospital stay 2 day.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right carpal tunnel release: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Carpal Tunnel Chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270-73.

Decision rationale: The California MTUS guidelines recommend decompression when the patient has not improved following steroid treatment. Documentation does not show the patient received steroids. The guidelines recommend decompression when the patient's symptoms indicate compression of the median nerve and the patient has not improved with a treatment with a splint. Documentation does not show this. The requested right carpal tunnel release is not medically necessary and appropriate.

C6-7 Anterior Cervical Discectomy and Fusion (ACDF): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 180. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back Chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178-80.

Decision rationale: The California MTUS guidelines recommend cervical surgery when the patient has had severe persistent, debilitating upper extremity complaints referable to a specific nerve root or spinal cord level corroborated by clear imaging, clinical examination and electrophysiological studies. The guidelines note the patient would have failed a trial of conservative therapy. Documentation does not provide this evidence. The guidelines note the surgical repair proposed for the lesion must have evidence of efficacy both in the short and long term. The requested treatment: C6-7 Anterior Cervical Discectomy and Fusion (ACDF) is not medically necessary and appropriate.

Preoperative labs: Complete Blood Count (CBC), Comprehensive Metabolic Panel (CPM), Prothrombin Time (PT) and International Normalized Ratio (INR): 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: 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.

Associated surgical service: Inpatient hospital stay, 2 day: 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.