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| <b>Case Number:</b>   | CM15-0014826 |                              |            |
| <b>Date Assigned:</b> | 02/02/2015   | <b>Date of Injury:</b>       | 08/07/2008 |
| <b>Decision Date:</b> | 04/24/2015   | <b>UR Denial Date:</b>       | 01/14/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 01/26/2015 |

### 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: 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 American College of Occupational and Environmental Medicine indicates that a surgical consultation may be appropriate for patients who have activity limitation for more than 1 month or with extreme progression of symptoms. There should be documentation of clear clinical, imaging, and electrophysiological evidence consistently indicating the same lesion that has been shown to benefit from surgical repair in both the short and long term. There should be documentation of unresolved radicular symptoms after receiving conservative treatment. The efficacy of cervical fusion for patients with chronic cervical pain without instability has not been demonstrated. There was imaging evidence to support the necessity for intervention. The documentation indicated the injured worker had myotomal findings in the left upper extremity and decreased deep tendon reflexes in the left upper extremity. The sensation was within normal limits in the bilateral upper extremities. The fusion would be supported if the cervical discectomy was performed as the need instability would be created during the surgical procedure. There was a lack of documentation of a failure of conservative care. However, given the lack of documentation of the electrophysiologic studies, the request for anterior cervical discectomy and fusion (ACDF) C5-C7 is not medically necessary.

### IMR ISSUES, DECISIONS AND RATIONALES

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

## **Anterior Cervical Discectomy and Fusion (ACDF) C5-C7: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guideline (ODG); Work Loss Data Institute, Neck & Upper Back (Acute & Chronic).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): s 179-181.

**Decision rationale:** The American College of Occupational and Environmental Medicine indicates that a surgical consultation may be appropriate for patients who have activity limitation for more than 1 month or with extreme progression of symptoms. There should be documentation of clear clinical, imaging, and electrophysiological evidence consistently indicating the same lesion that has been shown to benefit from surgical repair in both the short and long term. There should be documentation of unresolved radicular symptoms after receiving conservative treatment. The efficacy of cervical fusion for patients with chronic cervical pain without instability has not been demonstrated. There was imaging evidence to support the necessity for intervention. The documentation indicated the injured worker had myotomal findings in the left upper extremity and decreased deep tendon reflexes in the left upper extremity. The sensation was within normal limits in the bilateral upper extremities. The fusion would be supported if the cervical discectomy was performed as the need instability would be created during the surgical procedure. There was a lack of documentation of a failure of conservative care. However, given the lack of documentation of the electrophysiologic studies, the request for anterior cervical discectomy and fusion (ACDF) C5-C7 is not medically necessary.

## **2 Day 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.

## **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.

**Labs: CBC, CMP, PT, PTT, UA:** 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.

**EKG:** 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.

**Chest X-ray:** 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.