

<b>Case Number:</b>	CM15-0057250		
<b>Date Assigned:</b>	04/02/2015	<b>Date of Injury:</b>	05/01/2011
<b>Decision Date:</b>	05/04/2015	<b>UR Denial Date:</b>	03/18/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/25/2015

### 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 58 year old female, who sustained an industrial injury on 05/01/2011. She has reported injury to the neck, shoulders, arms, and upper back. The diagnoses have included cervical degenerative disc disease, cervical spondylosis; cervical radiculopathy; cervical disc protrusion; and sprain/strain/impingement of the right and left shoulder. Treatment to date has included medications, diagnostics, bracing, epidural steroid injections, acupuncture, chiropractic, and physical therapy. A progress note from the treating physician, dated 02/03/2015, documented a follow-up visit with the injured worker. Currently, the injured worker complains of continued neck pain radiating to her arms with weakness and tingling in her upper extremities. Objective findings included tenderness to palpation over trapezius muscles; compression test positive; crepitus with flexion; restricted range of motion of the cervical spine due to pain; and she has not responded to conservative treatments. The treatment plan has included anterior cervical discectomy and fusion with instrumentation at C3-4, C4-5, C5-6, C6-7; pre-operative (spine fusion) psychological clearance; post-operative physical therapy, 4 weeks; post-operative cervical collar; and post-operative cold therapy and bone stimulator.

### 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 w/ instrumentation at C3-4, C4-5, C5-6, C6-7:**  
Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 180,183.

**Decision rationale:** The California MTUS guidelines note that surgical consultation is indicated if the patient has persistent, severe and disabling shoulder and arm symptoms. The documentation shows this patient has been complaining of pain in the neck and trapezius. Documentation does not disclose disabling shoulder and arm symptoms. The guidelines also list the criteria for clear clinical, imaging and electrophysiological evidence consistently indicating a lesion which has been shown to benefit both in the short and long term from surgical repair. The PR2 of 3/03/15 indicates NCV findings of bilateral ulnar neuropathy with recommendations for elbow splints and pads. Documentation does not show evidence of a home exercise program or any strengthening program for her upper extremities. The documentation does not contain objective evidence correlating the patient's physical examination with her imaging studies. The requested treatment is for a multilevel anterior cervical discectomy and fusion. The PR2 of 2/26/15 only mentions compression of the left C7 nerve root. The guidelines note that the efficacy of fusion without instability has not been demonstrated. Documentation does not show pathologic instability. The requested treatment: Anterior Cervical Discectomy and fusion w/ instrumentation at C3-4, C4-5, C5-6, C6-7 Is NOT Medically necessary and appropriate.

**Pre-Operative (Spine Fusion) Psychological Clearance:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Neck & Upper Back chapter; Low Back chapter.

**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.

**Post-Operative Physical Therapy, 4 Weeks:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

**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.

**Post-Operative Cervical Collar: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Neck & Upper Back chapter.

**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.

**Post-Operative Cold Therapy and Bone Stimulator: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 299, 308. Decision based on Non-MTUS Citation Official Disability Guidelines: Knee chapter.

**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.