

Case Number:	CM15-0085917		
Date Assigned:	05/08/2015	Date of Injury:	05/23/2014
Decision Date:	06/11/2015	UR Denial Date:	05/01/2015
Priority:	Standard	Application Received:	05/05/2015

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 49 year old female who sustained an industrial injury on 5/23/14 following an altercation with a resident of the psychiatric facility where she works and was struck several times. She developed neck and low back pain. She currently (4/23/15) complains of severe posterior cervical neck and interscapular region pain with pain radiating into the bilateral shoulders, arms, forearms and hands. Medications include Propanalol. Diagnoses include C5-6 focal advanced degenerative disc disease and severe bilateral foraminal stenosis. Treatments to date include physical therapy with traction, acupuncture and medication with no benefit. Diagnostics include MRI of the cervical spine (4/27/15) showing degenerative changes and severe bilateral foraminal stenosis; MRI of the lumbar spine (9/4/14) showing no significant disc protrusion or stenosis; electromyography/nerve conduction test (3/17/15) did not show any evidence of carpal tunnel syndrome or ulnar neuropathy. In the treating provider's plan of care dated 4/23/15 the treating provider requested a C5-6 anterior cervical decompression with fusion and instrumentation. He notes one year of ongoing severe neck and bilateral upper extremity radicular pain that has failed conservative treatment.

IMR ISSUES, DECISIONS AND RATIONALES

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

C5-6 Anterior Cervical Discectomy, with decompression of spinal cord and/or nerve root(s)
Qty: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): S 180-181.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): s 178-181.

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 EMG and NCV's were normal. Radiologist did not diagnose severe foraminal encroachment. The guidelines note the patient would have failed a trial of conservative therapy. 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: C5-6 Anterior Cervical Discectomy, with decompression of spinal cord and/or nerve root(s) QTY: 1.00 is NOT Medically necessary and appropriate.

C5-6 Arthrodesis, anterior interbody QTY: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): s 180-181.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): s 178-181.

Decision rationale: The California MTUS guidelines do recommend a spinal fusion for traumatic vertebral fracture, dislocation and instability. This patient has not had any of these events. The guidelines note that the efficacy of fusion in the absence of instability has not been proven. 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. 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: C5-6 Arthrodesis, anterior interbody QTY: 1.00 is NOT Medically necessary and appropriate.

Anterior instrumentation, 2 to 3 vertebral segments Qty: 1.00: 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.

Application of intervertebral biomechanical devices Qty: 1.00: 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.

Microsurgical techniques: 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 stay # day (s) Qty: 1.00: 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 PAC QTY: 1.00: 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.

Post op Aspen Cervical Collar QTY: 1.00: 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.

Pre-op Medical Clearance QTY: 1.00: 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.

Post-op Follow- up QTY: 1.00: 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.