

Case Number:	CM14-0131710		
Date Assigned:	08/20/2014	Date of Injury:	08/04/2010
Decision Date:	10/29/2014	UR Denial Date:	08/14/2014
Priority:	Standard	Application Received:	08/18/2014

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. The expert reviewer is Board Certified in Orthopedic Spine Surgery and is licensed to practice in Texas. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 51-year-old female who reported an injury on 08/04/2010. The mechanism of injury involved repetitive activity. Previous conservative treatment is noted to include chiropractic treatment, multiple medications, and physical therapy. The current diagnoses include chronic axial neck pain, bilateral arm numbness and tingling, rule out cervical instability, rule out bilateral upper extremity peripheral neuropathy, and thyroid enlargement. The injured worker was evaluated on 06/27/2014 with complaints of persistent neck pain and headaches. The current medication regimen includes tramadol, Motrin, lithium and Ambien. Physical examination of the cervical spine revealed tenderness to palpation over the lower cervical region, normal range of motion, negative Spurling's maneuver, positive Tinel's sign at the right wrist, normal motor strength in the bilateral upper extremities, 2+ deep tendon reflexes, and intact sensation. Treatment recommendations at that time included an anterior cervical discectomy and fusion at C5-6. There was no Request for Authorization form submitted for this review. It is noted that the injured worker underwent an MRI of the cervical spine on 06/06/2014, which indicated mild disc degeneration narrowing at C5-6 with annular disc bulging and right C6 nerve compression. The injured worker also underwent electrodiagnostic testing on 05/14/2014, which indicated no evidence of cervical radiculopathy.

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 C5-6: 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: Upper Neck & Back (Updated 08/04/14) Discectomy- Laminectomy-Laminoplasty

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 179-180. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck & Upper Back Chapter, Fusion, anterior cervical

Decision rationale: California MTUS/ACOEM Practice Guidelines state a referral for surgical consultation is indicated for patients who have persistent, severe and disabling shoulder or arm symptoms, activity limitation for more than 1 month, clear clinical, imaging and electrophysiologic evidence of a lesion, and unresolved radicular symptoms after receiving conservative treatment. The Official Disability Guidelines recommend an anterior cervical fusion for spondylotic radiculopathy where there are significant symptoms that correlate with physical examination findings and imaging reports. There should be documented persistent or progressive radicular pain or weakness secondary to nerve root compression. The injured worker's physical examination did not reveal any evidence of motor weakness or sensory deficit. There is no objective evidence of a significant functional limitation. There was no documentation of spinal instability upon flexion and extension view radiographs. The medical necessity for the requested procedure has not been established. As such, the request is not medically necessary.

Inpatient Hospital Stay X1 Day: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Hospital Length of Stay (LOS)

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 base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back (updated 07/03/14)

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.

Medical Clearance: Labs: 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.

Medical Clearance: 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.

Medical Clearance: 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..

Bone Growth Stimulator: 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.

Dme: Aspen Cervical Collar/ in office fit: 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.