

Case Number:	CM14-0163642		
Date Assigned:	10/08/2014	Date of Injury:	01/20/2014
Decision Date:	11/12/2014	UR Denial Date:	09/26/2014
Priority:	Standard	Application Received:	10/06/2014

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 Surgeon 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 40 year old male who reported a date of injury of 01/20/2014. The mechanism of injury was documented as cumulative trauma. The diagnoses for this injured worker are left-sided C4-C5 disc herniation with nerve root impingement and left C5 radiculopathy. Documentation of 08/25/2014 indicated he had had two epidural steroid injections under fluoroscopy, the second on 08/18/2014, without benefit. It was also noted on this date that the injured worker had a course of conservative therapy. There was no documentation that indicated of what the therapy consisted, nor the length of time it was utilized. Cervical MRI of 02/22/2014 indicated foraminal narrowing and disc protrusions on 5 levels. He had an X-ray but the report was not included and date was uncertain. The injured worker stated neck pain at 3-4 on a scale of 1-10 which radiates into the left shoulder and hand. He also reported numbness and tingling in the left arm. The pain increased with neck movement, reaching or lifting, or prolonged sitting and standing. He stated pain of the left shoulder was 4-5. As documented on 08/25/2014 physician's assessment the injured work had right arm strength 5/5 and left 4/5, sensation was intact except at C5, range of motion was decreased with flexion 15/45, extension 25/45, right lateral tilt 30/45, left lateral tilt 20/45, right lateral rotation 45/60, left lateral rotation 50/60. Also revealed was decreased sensation, left C5 distribution with decreased strength in the left upper extremity in all the muscle groups secondary to pain. The documentation stated the injured worker is currently taking anti-inflammatory medication as needed, but the dosage, frequency and rational for use were not included. The proposed treatment plan included preoperative clearance from an internal medicine physician, anterior cervical discectomy and fusion at C4-5 with a bone growth stimulator, postoperative physical therapy, a home health nurse for dressing changes, and a cervical brace. The rationale for surgery was to relieve the

pressure on the nerve and potentially diminish risk of further damage to the nerve and improving his symptoms. A Request for Authorization is included and dated 09/18/2014.

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 at C4-C5: 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, Indications for surgery- Discectomy/laminectomy (excluding fractures) Neck & Upper Back (Acute & Chronic)

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

Decision rationale: The California MTUS ACOEM guidelines state surgery is considered for serious spinal pathology, nerve root compression not responsive to an adequate trial of conservative therapy generally considered to require at least 6 weeks, or the development of a documented, progressive neurological deficit. Disc herniation, characterized by protrusion (or extrusion, which is also referred to as a "free fragment") of the central nucleus pulposus through a defect in the outer annulus fibrosus, may impinge on a nerve root typically causing mostly referred shoulder and arm symptoms accompanied by nerve root dysfunction. However, the presence of a herniated disc on an imaging study is common and in isolation, does not imply nerve root dysfunction. The medical records submitted do not include any details of the conservative treatment used, except for Ibuprofen and epidural steroid injections. There was no documentation of first-line medication such as muscle relaxers or opioids. There was also a lack of documentation as to any trials of physical therapy, occupational therapy, or chiropractic care to improve functionality. The injured worker reported numbness and tingling of the left arm with a strength of 4/5, but there is no documentation regarding a progression of neurological deficit. Since definitive conservative care has not been documented, the guidelines do not support the request for anterior cervical discectomy and fusion at C4-C5. In consideration of the evidence the request is not medically necessary.

1 internal medicine pre-operative medical clearance: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Surgery General Information and Ground rules, California Official Medical Fee schedule, 1999 edition pages 92-93

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 RN assessment for wound care and home aid as needed: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain 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.

12 Post-operative physical therapy sessions: 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.

Request for 1 brace: 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.

1 bone growth stimulator unit: 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.