

<b>Case Number:</b>	CM14-0178236		
<b>Date Assigned:</b>	11/03/2014	<b>Date of Injury:</b>	08/01/2002
<b>Decision Date:</b>	12/17/2014	<b>UR Denial Date:</b>	09/25/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/27/2014

### 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 California. 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:

This is a 61 year old female with an 8/1/02 injury date. In a 6/24/14 follow-up, the patient complained of cervical stiffness and headaches, upper extremity weakness, and right arm pain. Objective findings included reduced cervical motion and tenderness. A 7/23/14 cervical MRI showed C6-7 anterior cervical fusion without hardware complication, C5-6 mild bilateral foraminal stenosis from bony hypertrophy, and C4-5 normal disc and no appreciable central foraminal stenosis. In a 8/25/14 follow-up, objective findings included "weakness in the upper extremities bilaterally, normal motor and sensory upper extremities." The provider commented that the recent cervical MRI showed disc bulges at both C4-5 and C5-6. Diagnostic impression: cervical radiculopathy, spondylosis, disc herniation. Treatment to date: epidural steroid injection, medications. A UR decision on 9/23/14 denied the request for anterior cervical decompression and fusion C4-6, iliac crest bone graft through a separate fascial incision, and placement of prosthetic device C4-6 instrumentation with cervical plating because there was no documentation of abnormal findings at the C4-5 level in the formal MRI report. The requests for pre-op labs, UA, EKG, chest x-ray, neuromonitoring, cell saver technician, assistant surgeon, and cold therapy unit were denied because the associated surgical procedures were not certified.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Anterior cervical decompression & Fusion C4-C6, Iliac Crest Bone Graft through separate fascial incision, placement of prosthetic device C4-C6 instrumentation with cervical plating:** 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 (ODG)

**MAXIMUS 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 (ODG): Neck and Upper Back Chapter--Anterior cervical discectomy and fusion (ACDF)

**Decision rationale:** CA MTUS criteria for cervical decompression include persistent, severe, and disabling shoulder or arm symptoms, activity limitation for more than one month or with extreme progression of symptoms, clear clinical, imaging, and electrophysiology evidence, consistently indicating the same lesion that has been shown to benefit from surgical repair both in the short and the long term, and unresolved radicular symptoms after receiving conservative treatment. In addition, ODG states that anterior cervical fusion is recommended as an option in combination with anterior cervical discectomy for approved indications. However, in this case there is a discrepancy between the provider's interpretation of the MRI and the official MRI report. The provider interprets significant pathology at C4-5 whereas the MRI report does not. Therefore, the medical necessity of performing cervical fusion at C4-5 is questionable at this time. Another concern is the lack of specific objective exam documentation. In the available follow-up notes, there is no documentation of motor/sensory/reflex disturbances at any specific spinal level. Therefore, the request for Anterior cervical decompression & Fusion C4-C6, Iliac Crest Bone Graft through separate fascial incision, placement of prosthetic device C4-C6 instrumentation with cervical plating is not medically necessary.

**Associated surgical service: Pre-op labs: Pre-op labs: CBC, PT/PTT, INR, Hgb, BMP, & HFP:** 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: Pre-op labs: Pre-op UA Complete:** 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: Pre-op 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.

**Associated surgical service: Pre-op 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.

**Associated surgical service: Neuro Monitoring Consisting of Intra-Operative Monitoring SSEP & EMG: 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: Cell saver technician: 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: 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.

**Associated surgical service: Post-op DME rental Cold Unit x 30 days:** 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 (ODG)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Knee Chapter-- Continuous-flow cryotherapy.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Associated surgical service: Post-op DME purchase Bone 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.

**Associated surgical service: Post-op DME purchase Cervical Collar:** 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: Post-op Physical Therapy 2 x 4 to cervical spine:** 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 x 2-3 days:** 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: Medical Clearance:** 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 (ODG)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: ACC/AHA 2007 Guidelines on perioperative cardiovascular evaluation and care for noncardiac surgery

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.