

Case Number:	CM13-0060004		
Date Assigned:	12/30/2013	Date of Injury:	06/10/2008
Decision Date:	03/16/2015	UR Denial Date:	11/19/2013
Priority:	Standard	Application Received:	12/02/2013

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: California

Certification(s)/Specialty: Orthopedic Surgery, Sports Medicine

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 male who reported injury on 06/09/2010. The mechanism of injury was not provided. Diagnostic studies included an MRI of the cervical spine on 10/07/2013, which revealed the injured worker had fusion at C5-7 and there was posterior spurring and bulging at C4-5, which narrowed the thecal sac to approximately 9.1 mm; appearance was similar to the previous CT scan; there was some foraminal narrowing on the right at C4-5 and at C3-4, unchanged from the prior CT. The documentation of 10/28/2013 revealed the injured worker had a prior anterior plate fixation at C6-7 and an anterior discectomy and interbody fusion at C5-6. The physician documented there was radiographic evidence of nonunion at C5-6 and a herniated disc at C4-5. Recommendation would be a revision surgery at C5-6 with interbody fusion and discectomy and artificial disc replacement at C4-5 with removal of hardware at C6-7. The physician further documented fusion is not necessary at C6-7, but a nonunion at C5-6 needs to be addressed with additional instrumentation and fusion if there is a nonunion at C5-6 currently. The physician indicated the injured worker had a herniated disc at C4-5 and was a candidate for decompression and artificial disc replacement C4-5, as opposed to fusion at this location. If there was a fusion at C4-5 and a revision surgery at C5-6 there would be problems at C3-4. The physician documented the injured worker had spondylosis seen on CT of 02/14/2013, which indicated C4-5 facet hypertrophy and uncovertebral spondylosis. The official MRI revealed the facet minimal degenerative changes; a the level of C4-5 there was uncovertebral hypertrophy of the right resulting in mild to moderate foraminal narrowing similar to the CT scan; there was some narrowing of the disc space with posterior spurring and bulging

causing several millimeters encroachment on the anterior thecal sac. Prior therapies included physical therapy and chiropractic care. There was no Request for Authorization submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

REDO ANTERIOR CERVICAL FUSION C5-C6: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. 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): 179-181.

Decision rationale: The American College of Occupational and Environmental Medicine indicates that a surgical consultation may be appropriate for patients who have activity limitation for more than 1 month or with extreme progression of symptoms. There should be documentation of clear clinical, imaging, and electrophysiological evidence consistently indicating the same lesion that has been shown to benefit from surgical repair in both the short and long term. There should be documentation of unresolved radicular symptoms after receiving conservative treatment. The efficacy of cervical fusion for patients with chronic cervical pain without instability has not been demonstrated. There would be no necessity for electrophysiologic evidence as a fusion does not require neurologic findings. There was a lack of documentation of instability per flexion and extension studies. There was a lack of documentation of a failure of an exhaustion of conservative care. Additionally, the request per the physician documentation was for a redo, not for radio; however, this was not a basis for denial. Given the above, the request for radio anterior cervical fusion C5-6 is not medically necessary.

INPATIENT STAY FOR 2 DAYS: Upheld

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

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.

NEUROMONITORING: Upheld

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

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-OPERATIVE HISTORY AND PHYSICAL: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation

<http://www/guidelines.gov/content.aspx?id=38289>Pre-operative Evaluation

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-OPERATIVE LABORATORIES, CHEST X-RAY AND EKG: Upheld

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

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.

DECOMPRESSION AND ARTIFICIAL DISC REPLACEMENT AT THE C4-C5: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 8, 181-183.

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.