

Case Number:	CM14-0140185		
Date Assigned:	09/08/2014	Date of Injury:	11/08/1993
Decision Date:	05/01/2015	UR Denial Date:	08/05/2014
Priority:	Standard	Application Received:	08/29/2014

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. 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: Oregon, California
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 a 48-year-old male who reported an injury on 11/08/1993. The mechanism of injury was not stated. The current diagnoses include myofascial pain syndrome, lumbar disc degeneration, and degeneration of thoracic or thoracolumbar intervertebral disc. The latest physician progress report submitted for this review is documented on 11/07/2014. The injured worker presented with complaints of persistent low back pain with radiating symptoms into the right lower extremity. Upon examination, there was tenderness to palpation over the thoracic spinous process and bilateral thoracic muscles. There was no documentation of a physical examination of the cervical spine noted. Recommendations included continuation of the current medication regimen. There was no Request for Authorization form submitted for this review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Anterior C7-T1 Discectomy, Allograft Fusion and Instrumentation: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 179 and 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 anterior cervical fusion for spondylotic radiculopathy when there are significant symptoms that correlate with physical exam findings and imaging reports, persistent or progressive radicular pain or weakness secondary to nerve root compression, and at least 8 weeks of conservative therapy. In this case, there was no documentation of a comprehensive examination of the cervical spine. There was also no documentation of spinal instability upon flexion and extension view radiographs prior to the request for a fusion. There were no official imaging studies provided for review. Given the above, the request is not medically appropriate at this time.

Associated surgical service: One Day Inpatient Stay: Upheld

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

Associated surgical service: Assistant Surgeon: Upheld

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

Post-Operative X-Rays: AP/Lateral Cervical X-Ray: Upheld

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

Pre-Op Testing To Include Pre-Op Eval with Surgeon With Primary Treating Physician with an EKG for Medical Clearance Pre-Op Chest X-Ray and Pre-Op Laboratory Services: CBC Inc Platelets, Chem 12, Pt, PTT, and UA with and without Micro: Upheld

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