

Case Number:	CM14-0212157		
Date Assigned:	01/02/2015	Date of Injury:	06/04/2013
Decision Date:	02/28/2015	UR Denial Date:	12/03/2014
Priority:	Standard	Application Received:	12/18/2014

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. 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: Texas
 Certification(s)/Specialty: Orthopedic 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 55-year-old male who reported an injury on 06/04/2013. The mechanism of injury involved cumulative trauma. The injured worker is currently diagnosed with cervical myelopathy. The injured worker presented on 11/14/2014 with complaints of persistent neck pain with radiation into the bilateral hands. Previous conservative treatment includes physical therapy and medication management. Upon physical examination, there was 70 degrees flexion, 30 degrees extension, 70 degrees right and left rotation, positive Romberg's test, positive Spurling's test on the right, 4/5 wrist extensor strength, slight decrease in sensation in the left C6 distribution, 3+ deep tendon reflexes, and mildly unsteady gait. Treatment recommendations at that time included a cervical discectomy and fusion. A Request for Authorization form was then submitted on 11/19/2014. It is noted that the injured worker underwent an MRI of the cervical spine on 05/23/2013, which revealed evidence of degenerative disc changes at C4-7 with foraminal stenosis at C4-5 and C5-6.

IMR ISSUES, DECISIONS AND RATIONALES

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

Anterior Cervical Decompression and Fusion at C3-6: 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 (ODG) Neck & Upper Back-Fusion, Anterior Cervical; 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 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. According to the documentation provided, the injured worker has exhausted conservative treatment. However, there was no documentation of spinal instability upon flexion and extension view x-rays. It was also noted that the injured worker was diagnosed with a left shoulder rotator cuff tear and acromioclavicular osteoarthritis and was recommended to address the shoulder problem prior to surgical intervention for the cervical spine. Based on the clinical information received and the above mentioned guidelines, the request is not medically necessary medically appropriate at this time.

Associated Surgical Service: Pre-Op Labs to include a Complete Blood Count (CBC), Basic Metabolic Panel (BMP), Prothrombin Time (PT), Partial Thromboplastin Time (PTT), Urinalysis (UA): 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: Chest x-rays: 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: Initial Post-Op Physical Therapy to the Cervical Spine (2 times weekly for 8 weeks): 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.