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| Case Number: | CM14-0218339 | | |
| Date Assigned: | 01/08/2015 | Date of Injury: | 05/20/2009 |
| Decision Date: | 03/12/2015 | UR Denial Date: | 12/05/2014 |
| Priority: | Standard | Application Received: | 12/30/2014 |

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 52-year-old male who reported an injury on 05/20/2009. The mechanism of injury involved repetitive trauma. The injured worker is currently diagnosed with C5-6 and C6-7 discogenic neck pain with foraminal stenosis, narrowing and radiculopathy. The injured worker was evaluated on 09/15/2014 with complaints of ongoing pain in the cervical spine with radiation into the bilateral upper extremities. Upon examination there was midline and paraspinal tenderness of the cervical spine, decreased sensation in the right C7 and C8 distribution, decreased sensation in the left C7 distribution and diminished grip strength bilaterally. Recommendations included an anterior cervical discectomy and fusion at C5-6 and C6-7. 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:

Supportive Psychiatric Treatment QTY: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 398.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 101-102.

Decision rationale: The California MTUS Guidelines state psychological treatment is recommended for appropriately identified patients during treatment for chronic pain. However, the specific type of supportive psychiatric treatment was not listed in the request. As such, the request is not medically appropriate.

Surgery: Anterior Cervical Discectomy and Fusion at C5-C6 QTY: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 180-181.

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: The 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 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, and at least 8 weeks of conservative treatment. There was no evidence of spinal instability upon flexion and extension view radiographs. There were no imaging reports submitted for this review. The medical necessity has not been established in this case. As such, the request is not medically appropriate.

Surgery: Anterior Cervical Discectomy and Fusion at C6-C7 QTY: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 180-181.

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: The 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 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, and at least 8 weeks of conservative treatment. There was no evidence of spinal instability upon flexion and extension view radiographs. There were no imaging reports submitted for this review. The medical necessity has not been established in this case. As such, the request is not medically appropriate.