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| <b>Case Number:</b>   | CM15-0013522 |                              |            |
| <b>Date Assigned:</b> | 02/02/2015   | <b>Date of Injury:</b>       | 05/13/2011 |
| <b>Decision Date:</b> | 03/31/2015   | <b>UR Denial Date:</b>       | 01/15/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 01/23/2015 |

### 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

### 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 (IW) is a 51 year old female, who sustained an industrial injury on May 13, 2011. She has reported pain in the neck and left upper extremity and was diagnosed with left-sided cervical disk herniation with stenosis and left upper extremity radiculopathy. Treatment to date has included radiographic imaging, diagnostic studies, physical therapy, steroid injections and surgical consultation. Currently, the IW complains of neck and left upper extremity pain and radiculopathy. MRI cervical spine 9/13/14 demonstrates C4/5 3mm left disc protrusion, moderate narrowing at C5/6 and C6/7 3 mm left foraminal protrusion. Exam note from 12/3/14 demonstrates neck pain radiating to the left upper extremity. Spurling test was noted to be positive. Decreased sensation is noted in the left C5 dermatome. The injured worker reported an industrial injury on 2011 resulting in chronic neck and left upper extremity pain. She was noted to have failed conservative therapies. On December 3, 2014, evaluation revealed continued pain as previously described. It was noted the previous treatments were ineffective. The physician recommended surgical intervention based on symptoms and previous radiographic imaging. On January 15, 2015, Utilization Review non-certified a request for anterior cervical discectomy and fusion, medical clearance, post-op physical therapy, Philadelphia collar, Aspen collar, cervical external bone stimulator, surgiStim and front wheeled walker, noting the MTUS, ACOEM Guidelines, (or ODG) was cited. On January 23, 2015, the injured worker submitted an application for IMR for review of the above requests.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Anterior cervical discectomy and fusion at C5-C6: 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, Fusion, anterior cervical

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

**Decision rationale:** Per the CA MTUS/ACOEM guidelines, Neck and upper back complaints, pages 181-183 surgery is not recommended for non radiating pain or in absence of evidence of nerve root compromise. There is no evidence of clinical radiculopathy at the C6 level on exam from 12/3/14 correlating with the MRI from 9/13/14. The patient has pain from the exam notes of but this does not correlate with any imaging findings which has pathology also at C4/5 and C6/7. Therefore the patient does not meet accepted guidelines for the procedure and the request is non-certified.

**Standard pre-operative medical clearance: 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.

**Supervised post-operative therapy three (3) times per week for four (4) 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.

**Associated surgical service: Philadelphia 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: Aspen 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: cervical external 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: SurgiStim:** 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: front wheel walker:** 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.