

<b>Case Number:</b>	CM15-0030262		
<b>Date Assigned:</b>	02/23/2015	<b>Date of Injury:</b>	11/27/2013
<b>Decision Date:</b>	05/14/2015	<b>UR Denial Date:</b>	01/16/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/18/2015

### 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: 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 33-year-old male who reported an injury on 11/27/2013. The mechanism of injury involved heavy lifting. The current diagnoses include multilevel cervical disc herniation, multilevel thoracic disc herniation, C6-7 severe stenosis with cord compression, cervical sprain with radicular symptoms, lumbosacral sprain, and thoracic sprain. The injured worker presented on 12/30/2014 for an evaluation with complaints of chronic neck pain. The injured worker reported radiating symptoms into the right shoulder as well as numbness and tingling in the bilateral upper extremities. The injured worker had completed 18 sessions of physical therapy, which provided only temporarily relief of symptoms. Upon examination, there was altered sensation in the bilateral upper extremities as well as weakness on neck flexion, bilateral thumb extension, and bilateral hand intrinsics. The injured worker also had tremors in the right hand. Treatment recommendations at that time included an anterior cervical discectomy and fusion at C5-6 with iliac crest bone graft. A Request for Authorization form was then submitted on 12/30/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Anterior Cervical Spine Discectomy and Fusion at C5-C6 with Iliac Crest Bone Graft:**  
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: Neck/Upper Back.

**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 spondylosis 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, it is noted that the injured worker has been previously treated with approximately 18 sessions of physical therapy. However, there is no documentation of an exhaustion of all conservative treatment. In addition, there were no official imaging studies provided for this review. There is no evidence of a significant functional deficit upon examination. There is no documentation of spinal instability upon flexion and extension view radiographs. Given the above, the request is not medically appropriate.

**Inpatient Hospital Stay (4-days):** 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.