

<b>Case Number:</b>	CM15-0074717		
<b>Date Assigned:</b>	04/24/2015	<b>Date of Injury:</b>	04/22/2002
<b>Decision Date:</b>	05/22/2015	<b>UR Denial Date:</b>	04/07/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/20/2015

### 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: New York

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 62 year old female, who sustained an industrial/work injury on 4/22/02. She reported initial complaints of neck pain. The injured worker was diagnosed as having cervical discopathy with upper extremity radiculitis, right shoulder impingement syndrome, left cubital tunnel syndrome, s/p bilateral carpal tunnel release, right ring finger release and left long finger release, and lumbar discopathy with radiculitis. Treatment to date has included medication, surgery (wrists and fingers), and physical therapy. MRI results were reported on 5/14/14. Currently, the injured worker complains of ongoing neck pain along with headaches that are migrainous in nature and tension between the shoulder blades. Per the primary physician's progress report (PR-2) on 2/26/15, there is constant severe pain in the cervical spine, intermittent pain in the bilateral wrists, frequent pain in the shoulders/left elbow, and constant pain in the low back. Examination revealed limited range of motion in the cervical spine, tingling and numbness to the anteriolateral shoulder and arm and lateral forearm and hand, greatest over the thumb, consistent with C5-6 dermatomal pattern. Biceps reflexes are asymmetrical. The right shoulder had tenderness around the anterior glenohumeral region and subacromial space. Hawkin's and impingement test is positive. The left elbow has positive Tinel's sign. The bilateral wrists range of motion is full but painful. The lumbar spine has tenderness with palpation over the paravertebral muscles with spasm with dysesthesia at L5-S1 dermatomes. The requested treatments include C3 through C6 and possible C6-C7 anterior cervical discectomy with implantation of hardware with co-surgeon; medical clearance, Post-

operative Minerva Mini Collar #1, Post-operative Miami J collar with thoracic extension, and Post-operative #1 bone stimulator purchase.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**C3 through C6 and possible C6-C7 anterior cervical discectomy with implantation of hardware with co-surgeon; medical clearance: 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 - Fusion, anterior cervical.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178-80.

**Decision rationale:** The California MTUS guidelines recommend cervical surgery when the patient has had severe persistent, debilitating, upper extremity complaints referable to a specific nerve root or spinal cord level corroborated by clear imaging, clinical examination and electrophysiological studies. The guidelines note the patient would have failed a trial of conservative therapy. The guidelines note the surgical repair proposed for the lesion must have evidence of efficacy both in the short and long term. The California MTUS guidelines do recommend a spinal fusion for traumatic vertebral fracture, dislocation and instability. This patient has not had any of these events. The guidelines note that the efficacy of fusion in the absence of instability has not been proven. The requested treatment: C3 through C6 and possible C6-C7 anterior cervical discectomy with implantation of hardware with co-surgeon; medical clearance is NOT Medically necessary and appropriate.

**Post-operative Minerva Mini Collar #1: 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.

**Post-operative Miami J collar with thoracic extension: 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.

**Post-operative #1 bone stimulator purchase:** 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.