
Independent Medical Review Final Determination Letter

[REDACTED]
[REDACTED]
[REDACTED]

Dated: 12/26/2013

IMR Case Number:	CM13-0010122	Date of Injury:	12/8/1998
Claims Number:	[REDACTED]	UR Denial Date:	7/25/2013
Priority:	Standard	Application Received:	8/12/2013
Employee Name:	[REDACTED]		
Provider Name:	[REDACTED] MD		
Treatment(s) in Dispute Listed on IMR Application:	Please reference utilization review determination letter		

DEAR [REDACTED]

MAXIMUS Federal Services has completed the Independent Medical Review (“IMR”) of the above workers’ compensation case. This letter provides you with the IMR Final Determination and explains how the determination was made.

Final Determination: UPHOLD. This means we decided that none of the disputed items/services are medically necessary and appropriate. A detailed explanation of the decision for each of the disputed items/services is provided later in this letter.

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers’ Compensation. This determination is binding on all parties.

In certain limited circumstances, you can appeal the Final Determination. Appeals must be filed with the Workers’ Compensation Appeals Board within 30 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4610.6(h).

Sincerely,

Paul Manchester, MD, MPH
Medical Director

cc: Department of Industrial Relations, [REDACTED]

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Neurologic Surgery and is licensed to practice in California. 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 physician 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/services.

DOCUMENTS REVIEWED

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]

CLINICAL CASE SUMMARY

The physician reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

48 year old male with chronic neck pain underwent a 2 level cervical laminectomy because of neck pain and right upper extremity pain. Those symptoms continue. He has undergone PT/acupuncture/chiropractic without relief and taken meds which have not helped. His exam shows no weakness or loss of function. His MRI shows deg facet changes especially on Right. His CT shows loss of disc height at multiple levels. Xrays show solid fusion of Anterior Cervical Discectomy and Fusion (ACDF) at C6-7 and no motion with flexion/extension. His surgeon proposes ACDF of C4-5,5-6,6-7.

IMR DECISION(S) AND RATIONALE(S)

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

1. C4-5, C5-6 and C6-7 anterior cervical discectomy and fusion is not medically necessary and appropriate.

The Claims Administrator based its decision on the ACOEM Guidelines, Chapter 8 (Neck and Upper Back Complaints) (2004), pg. 183, which is a part of the MTUS.

The Expert Reviewer found that no section of the MTUS was applicable. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Expert Reviewer based his/her decision on Bambakidis NC et al. Indications for surgical fusion of the cervical and lumbar motion segment. SPINE 30:2,2005; 2013 Procedures Adult Criteria:Fusion,cervical spine and Milliman Care Guidelines 17th ed.Cervical Fusion,anterior, which are not a part of the MTUS.

The Physician Reviewer's decision rationale:

After a review of the records provided, this employee has chronic neck pain. The pain generator has not been identified. The employee has undergone at least one neck surgery, the most recent was a cervical laminectomy, which has not alleviated the pain. There are no localizing features that show what levels of this proposed surgery are the source of his pain. The employee has no evidence of a disc herniation which matches the symptoms nor exam. There is no evidence of radiculopathy, myelopathy, instability, fracture, infection, nor tumor. These are all criteria of Milliman, InterQual, and Bambakidis for an anterior cervical discectomy and fusion.

2. Three day inpatient stay is not medically necessary and appropriate.

Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Disclaimer: MAXIMUS is providing an independent review service under contract with the California Department of Industrial Relations. MAXIMUS is not engaged in the practice of law or medicine. Decisions about the use or nonuse of health care services and treatments are the sole responsibility of the patient and the patient's physician. MAXIMUS is not liable for any consequences arising from these decisions.

[REDACTED]

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