

---

**Notice of Independent Medical Review Determination**

Dated: 10/2/2013

[REDACTED]

[REDACTED]

[REDACTED]

Employee: [REDACTED]  
Claim Number: [REDACTED]  
Date of UR Decision: 7/8/2013  
Date of Injury: 4/9/2013  
IMR Application Received: 7/18/2013  
MAXIMUS Case Number: CM13-0001991

- 1) MAXIMUS Federal Services, Inc. has determined the request for C5-C7 anterior cervical discectomy and fusion, and C5-C7 anterior cervical instrumentation **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for a cervical collar **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for post-operative physical therapy 3 x a week for 6 weeks **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for an external bone growth stimulator purchase **is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/18/2013 disputing the Utilization Review Denial dated 7/8/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/23/2013. A decision has been made for each of the treatment and/or services that were in dispute:

- 1) MAXIMUS Federal Services, Inc. has determined the request for C5-C7 anterior cervical discectomy and fusion, and C5-C7 anterior cervical instrumentation **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for a cervical collar **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for post-operative physical therapy 3 x a week for 6 weeks **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for an external bone growth stimulator purchase **is not medically necessary and appropriate.**

### Medical Qualifications of the Expert Reviewer:

The independent Medical Doctor who made the decision has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Neurological 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 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 treatments and/or services at issue.

### Case Summary:

Disclaimer: The following case summary was taken directly from the utilization review denial/modification dated July 8, 2013:

According to the clinical documentation, the patient is a 37-year-old who sustained injuries while backing up the tractor loader, patient was looking to the left when the patient hit a bump on 4/09/13. This caused "him to jar his neck/shoulder" causing injuries to cervical spine and left shoulder. Prescription dated 5/24/13 by Dr. [REDACTED] documented a request for cervical collar post spinal fusion, external bone growth stimulation purchase post spinal fusion and post op physical therapy three times a week for six weeks. Medical report dated 5/22/13 by Dr. [REDACTED] documented the patient complained of intense pain in the neck and weakness that radiated down the arm, particularly on the left side. This was associated with numbness and tingling. Patient was placed in a cervical collar. Motor exam showed 3/5 weakness for triceps on the left and 4/5 weakness for bilateral deltoids, 5/5 strength for right triceps and 5/5 strength for bilateral biceps and hand grip. There was significant numbness and tingling that radiated down both arms, more so on the left than on the right. Treatment plan consisted of C5 to C7 anterior cervical discectomy and fusion. Magnetic resonance imaging (MRI) study of the cervical spine dated 5/07/13, interpreted by Dr. [REDACTED] documented the following impression: "1) At C5-C7, left posterolateral disc protrusion is seen with compression of the left side of the thecal sac and cord with

asymmetric effacement of the left lateral recess. 2) Subtle right paracoxial disc bulge with impression upon the thecal sac but no significant cord compression." X-ray of the cervical spine dated 5/07/13, interpreted by Dr. [REDACTED] documented the following impression: "1) Straightening of lumbar lordosis. This may be on the basis of patient positioning versus muscle spasm. 2) Question mid C5-6 intervertebral disc space narrowing." According to Request for authorization dated 6/28/13, the patient was diagnosed with spinal cord compression, stenosis and radiculopathy. This is a request for medical necessity of C5-C7 anterior cervical discectomy and fusion, C5-C7 anterior cervical instrumentation, surgical assistant, cervical collar, post-op physical therapy at three times a week for six weeks and external bone growth stimulator purchase.

### **Documents Reviewed for Determination:**

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

#### **1) Regarding the request for C5-C7 anterior cervical discectomy and fusion, and C5-C7 anterior cervical instrumentation:**

##### Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the American College of Occupational and Environmental Medicine (ACOEM) Guidelines, 2<sup>nd</sup> Edition, (2004), Neck and Upper Back Chapter, pages 181-183, which are part of the California Medical Treatment Utilization Schedule (MTUS). The Claims Administrator also cited the Official Disability Guidelines (ODG), Neck and Upper Back Chapter, Indications for Surgery Section, Fusion Section, and Plate Fixation Section, which are medical treatment guidelines that are not part of the MTUS. The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer relied on the section of the MTUS used by the Claims Administrator.

##### Rationale for the Decision:

The employee was injured on 4/9/13 and has experienced pain in the cervical spine and left shoulder. The provider has recommended treatment consisting of cervical collar post spinal fusion, external bone growth stimulation purchase post spinal fusion, and post-operative physical therapy three times per week for six weeks. A clinical evaluation dated 5/22/13 indicates the employee had significant numbness and tingling that radiated down both arms, more so on the left than right. The employee was placed in a cervical collar. A request was submitted for C5-C7 anterior cervical discectomy and fusion, and C5-C7 anterior cervical instrumentation.

The ACOEM Guideline indicates that when considering surgery for neck and upper back complaints, a patient's history, physical examination and imaging should be consistent with a specific lesion. The records submitted and reviewed do not demonstrate that surgery at the C5-6 level is indicated because the physical findings do not support C5-6 as the pain generator. In addition, the MRI findings show C5-6 is relatively normal considering the employee's age. The request for C5-C7 anterior cervical discectomy and fusion, and C5-C7 anterior cervical instrumentation **is not medically necessary and appropriate.**

**2) Regarding the request for a cervical collar:**

Rationale for the Decision:

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

**3) Regarding the request for post-operative physical therapy 3 x a week for 6 weeks:**

Rationale for the Decision:

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

**4) Regarding the request for external bone growth stimulator purchase:**

Rationale for the Decision:

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

**Effect of the Decision:**

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the final determination of the Administrative Director, Division of Workers' Compensation. With respect to the medical necessity of the treatment in dispute, this determination is binding on all parties.

In accordance with California Labor Code Section 4610.6(h), a determination of the administrative director may be reviewed only if a verified appeal is filed with the appeals board for hearing and served on all interested parties within 30 days of the date of mailing of the determination to the employee or the employer. The determination of the administrative director shall be presumed to be correct and shall be set aside only upon proof by clear and convincing evidence of one or more of the grounds for appeal listed in Labor Code Section 4610.6(h)(1) through (5).

Sincerely;

Richard C. Weiss, MD, MPH, MMM, PMP  
Medical Director

cc: Department of Industrial Relations  
Division of Workers' Compensation  
1515 Clay Street, 18<sup>th</sup> Floor  
Oakland, CA 94612

/sab

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.