
Notice of Independent Medical Review Determination

Dated: 10/16/2013

[REDACTED]

[REDACTED]

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/5/2013
Date of Injury: 3/4/2002
IMR Application Received: 7/19/2013
MAXIMUS Case Number: CM13-0002057

- 1) MAXIMUS Federal Services, Inc. has determined the request for Anterior Cervical Decompression and Fusion at the C6-7 level with allograft bone, interbody cage and anterior cervical plating **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for an Assistant Surgeon **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for Pre-op medical clearance **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for Post-op physical therapy for the cervical spine 2 times a week for 6 weeks **is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for cervical collar (off the shelf) **is not medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for soft cervical collar (off the shelf) **is not medically necessary and appropriate.**
- 7) MAXIMUS Federal Services, Inc. has determined the request for Muscle stimulator (off the shelf) **is not medically necessary and appropriate.**
- 8) MAXIMUS Federal Services, Inc. has determined the request for Hot/Cold Contract therapy **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/19/2013 disputing the Utilization Review Denial dated 7/5/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/25/2013. 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 Anterior Cervical Decompression and Fusion at the C6-7 level with allograft bone, interbody cage and anterior cervical plating **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for an Assistant Surgeon **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for Pre-op medical clearance **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for Post-op physical therapy for the cervical spine 2 times a week for 6 weeks **is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for cervical collar (off the shelf) **is not medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for soft cervical collar (off the shelf) **is not medically necessary and appropriate.**
- 7) MAXIMUS Federal Services, Inc. has determined the request for Muscle stimulator (off the shelf) **is not medically necessary and appropriate.**
- 8) MAXIMUS Federal Services, Inc. has determined the request for Hot/Cold Contract therapy **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 Orthopedic 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 5, 2013:

“According to the records made available for review, this is a 48-year-old male patient, s/p injury 3/4/02. The patient most recently (6/26/13) presented with pain from his neck radiating into both arms, which is associated with numbness and weakness. Physical examination

revealed motor deficit in the right C7 dermatome, positive Spurling's sign, and positive Lhermitte's sign. MRI Cervical Spine (3/23/12) report revealed 1.5mm central posterior disc protrusion at C6-7 level causing pressure over the anterior aspect of the thecal sac and mild narrowing of the left neural foramen. Current diagnoses include disc herniation C6-7 with myeloradiculopathy. Treatment to date includes activity modification, ESI, and medications. Treatment requested is Anterior Cervical Decompression and Fusion at the C6-7 level with allograft bone, interbody cage and anterior cervical plating, Assistant surgeon, Pre-op medical clearance, Post-op physical therapy for the cervical spine 2x6, Cervical collar (off the shelf), Soft Cervical Collar (off the shelf), Muscle Stimulator (off the shelf), and Hot/Cold Contrast Therapy (off the shelf)."

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:

- Application for Independent Medical Review (received 7/19/2013)
- Utilization Review Determination from [REDACTED] (dated 7/8/2013)
- Medical Records provided by the claims administrator and the employee's attorney
- Medical Treatment Utilization Schedule (MTUS)

1) Regarding the request for Anterior Cervical Decompression and Fusion at the C6-7 level with allograft bone, interbody cage and anterior cervical plating:

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), 2nd Edition, (2004) Chapter 8 Neck Upper Back pg. 179-180 which is a part of Medical Treatment Utilization Schedule (MTUS), and Official Disability Guidelines (ODG) Neck and Upper Back Chapter which is not a part of Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee sustained a work-related injury on March 4, 2002 to the neck and bilateral arms. The medical records indicate the diagnoses of disc herniation C6-7 with myeloradiculopathy. Treatments have included activity modification, epidural steroid injection (ESI), and medication management. The request is for Anterior Cervical Decompression and Fusion at the C6-7 level with allograft bone, interbody cage and anterior cervical plating.

The MTUS/ACOEM guidelines indicate that a decompression may be considered reasonable if there is persistent, severe, and disabling shoulder or arm symptoms, activity limitation for more than 1 month, or with extreme progression of symptoms, clear clinical, imaging, and electrophysiologic evidence consistently indicating the same lesion. The medical records, in this case, lack the documentation of symptoms like hyperreflexic, difficulty with balance, or long tract

signs supporting the diagnosis of myeloradiculopathy. Electrodiagnostic study was not provided for this review to document radiculopathy in the upper extremities. There is also lack of documentation of physical therapy notes or interventional injection which would indicate failure of conservative measures. Therefore, the request for Anterior Cervical Decompression and Fusion at the C6-7 level with allograft bone, interbody cage and anterior cervical plating **is not medically necessary and appropriate.**

2) Regarding the request for an Assistant Surgeon:

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

3) Regarding the request for Pre-op medical clearance:

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

4) Regarding the request for Post-op physical therapy for the cervical spine 2 times a week for 6 weeks:

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

5) Regarding the request for a Cervical collar (off the shelf):

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

6) Regarding the request for a soft cervical collar (off the shelf)

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

7) Regarding the request for a Muscle stimulator (off the shelf):

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), 2nd Edition, (2004), Forearm, Wrist and Hand Complaints Chapter 11), pg. 265 which is a part of Medical Treatment Utilization Schedule (MTUS), and Official Disability Guidelines (ODG), Pain Chapter which is not a part of Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer based his/her decision on MTUS Chronic Pain Guidelines, page 116.

Rationale for the Decision:

The employee sustained a work-related injury on March 4, 2002 to the neck and bilateral arms. The medical records indicate the diagnoses of disc herniation C6-7 with myeloradiculopathy. Treatments have included activity modification,

epidural steroid injection (ESI), and medication management. The request is for a muscle stimulator (off the shelf).

The MTUS Chronic Pain guidelines indicate that a TENS unit may be considered reasonable and necessary for chronic intractable pain with evidence of other appropriate pain modalities having been tried, including medication failed. A one-month trial period of a TENS unit should be tried with documentation of other ongoing pain treatment during the trial period, including medication usage, and a treatment plan including specific short and long term goals of treatment with the TENS unit also should be submitted. In this case, the medical records do not indicate a one-month trial has been utilized, and the treatment plan for this device with short and long term goals documented. Therefore, the request for a muscle stimulator (off the shelf) **is not medically necessary and appropriate.**

8) Regarding the request for Hot/Cold Contract Therapy (off the shelf):

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

The Claims Administrator did not cite any evidence-based guidelines. The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer based his/her decision on MTUS/ACOEM Guidelines, Neck Chapter.

Rationale for the Decision:

The employee sustained a work-related injury on March 4, 2002 to the neck and bilateral arms. The medical records indicate the diagnoses of disc herniation C6-7 with myeloradiculopathy. Treatments have included activity modification, epidural steroid injection (ESI), and medication management. The request is for hot/cold contract therapy (off the shelf).

The MTUS/ACOEM Guidelines indicates there is no high-grade scientific evidence to support the effectiveness or ineffectiveness of passive physical modalities such as traction, heat/cold applications, etc. The rationale for providing the employee with this device vs. at home applications of ice or heat has not been demonstrated in the medical records reviewed. Therefore, the request for hot/cold contract therapy **is not 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, 18th Floor
Oakland, CA 94612

/hs

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.