
Independent Medical Review Final Determination Letter

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

Dated: 12/19/2013

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/25/2013
Date of Injury: 4/29/2011
IMR Application Received: 8/8/2013
MAXIMUS Case Number: CM13-0008578

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 Orthopedic Surgery, and is licensed to practice in MT, TN and TX. 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:

The patient is a 50-year-old female who reported a work-related injury on 04/29/2011 as a result of cumulative trauma. Subsequently, the patient presents for treatment of the following diagnoses: displacement cervical disc without myelopathy, degeneration cervical disc, cervical spinal stenosis, and shoulder disorder. MRI of the cervical spine dated 04/26/2013, signed by Dr. [REDACTED] revealed (1) degenerative changes in the cervical spine without progression compared to prior MRI on 04/19/2012. (2) Mild spinal canal stenosis at the C4-5 level, which was unchanged compared to the prior MRI. (3) Mild spinal canal stenosis, and mild left neural foraminal narrowing at the C5-6 level, which was unchanged compared to the prior MRI. (4) Mild bilateral neural foraminal narrowing at the C6-7 level, which is unchanged compared to the prior MRI on 04/19/2012. The clinical note dated 07/17/2013 reports the patient was seen for follow-up under the care of Dr. [REDACTED]. The provider documents the patient has utilized physical therapy, injections to the shoulder, and refuses injections to the cervical spine. The provider documents the current evaluation is a second opinion determination of the patient's future treatment. The provider documents upon physical exam of the patient, the patient had 4/5 weakness with deltoids and biceps bilaterally, 5/5 motor strength noted throughout remaining motor groups. Sensory exam was significant for subjective complaints of numbness and tingling into the bilateral upper extremities. The provider documented treatment options with the patient including conservative care, interventional pain management procedures, and surgical intervention. The provider encouraged the patient to consider surgery as an absolute last option. The provider documented the patient understood. Incidentally, operative report dated 08/09/2013 reports the patient underwent left shoulder arthroscopic debridement of a glenoid labrum rotator cuff release of the biceps tendon, synovectomy, subacromial decompression, left distal clavicle excision, and biceps tenodesis of the left shoulder.

IMR DECISION(S) AND RATIONALE(S)

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

1. C3-C6 Anterior Cervical Discectomy Fusion/Anterior Cervical Instrumentation is not medically necessary and appropriate.

The Claims Administrator based its decision on the American College of Occupational and Environmental Medicine (ACOEM) guidelines, pg. 180, which is a part of the MTUS.

The Physician Reviewer based his/her decision on the Neck and Upper Back Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 8) pg. 179-180, Surgical Considerations, which is a part of the MTUS and the Official Disability Guidelines (ODG), Neck and Upper Back Chapter, which is not a part of the MTUS.

The Physician Reviewer's decision rationale:

A review of the records indicates that the current request previously received an adverse determination due to a lack of specific, objective findings of symptomatology following a specific dermatomal pattern correlating with imaging of the employee's cervical spine. In addition, imaging of the employee's cervical spine revealed all mild findings; there was no severe or moderate evidence of any neural foraminal narrowing or stenosis. California MTUS/ACOEM indicates, "Surgical considerations are supported for patients who present with persistent, severe, and disabling shoulder or arm symptoms, activity limitation for 1 month or with extreme progression of symptoms, and clear clinical imaging and electrophysiologic evidence consistently indicating the same lesion that has been shown to benefit from surgical repair in both the short and long-term, and (4) unresolved radicular symptoms after receiving conservative treatment." The clinical notes lack evidence of the employee presenting with severe, debilitating symptoms with physiologic evidence of specific nerve root or spinal cord dysfunction corroborated on appropriate imaging studies. **The request for C3-6 anterior cervical discectomy and fusion/anterior cervical instrumentation is not medically necessary and appropriate.**

2. Assistant surgeon is not medically necessary and appropriate.

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

3. Inpatient 1 day stay is not medically necessary and appropriate.

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

4. Cervical collar is not medically necessary and appropriate.

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

5. External Bone Growth Stimulator purchase is not medically necessary and appropriate.

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

6. Post operative Physical Therapy three times a week for six weeks 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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