

Case Number:	CM14-0156026		
Date Assigned:	09/30/2014	Date of Injury:	06/04/2013
Decision Date:	11/03/2014	UR Denial Date:	09/19/2014
Priority:	Standard	Application Received:	09/23/2014

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. The expert reviewer is Board Certified in Orthopedic Spine Surgery, and is licensed to practice in Texas. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 53-year-old female who reported injury on 06/04/2013. The mechanism of injury was not provided. The injured worker underwent x-rays of the lumbar spine which were noncontributory to the request. Prior surgeries included a laminectomy and a fusion. The injured worker underwent an EMG/NCV on 09/05/2014 which did not show radiculopathy. The injured worker underwent an MRI of the cervical spine on 09/05/2014 which revealed at the level of C3-4 there were disc disorders that did not compress the cord, slight anterior wedging of the C4 vertebral bodies that were old based on signal characteristics. The injured worker underwent x-rays of the cervical spine on 09/05/2014 which revealed severe disc height collapse at C3-4. Prior treatments included physical therapy. The injured worker underwent x-rays of the cervical spine on 09/05/2014 which revealed severe disc height collapse at C3-4. The physician documentation of 09/05/2014 revealed the injured worker had complaints of neck pain radiating to the bilateral upper extremities, dropping objects from both hands, and new walking difficulties. Prior treatments included physical therapy, NSAIDs, and Lyrica. Physical examination revealed the injured worker was in moderate discomfort while standing or sitting on the couch. The injured worker's gait was abnormal due to clumsiness resembling spasticity per the physician. The station was abnormal due to loss of lumbar spine lordosis. The Romberg was negative. The cervical examination revealed movements of the neck on extension, flexion, and right lateral rotation reproduced right arm symptoms. Muscle tone in the upper limbs was within normal limits and symmetrical. Muscle strength showed evidence of diminished strength in the right hand grip and slight weakness of the triceps muscle as compared with the left side. The injured worker was noted to be right handed. The somatic sensation as tested by pinroll showed diminished sensation at the right C6-7 dermatomes. The biceps supinator and triceps were 2 to 3+ symmetrically. The planar responses were down going on the left and equivocal on the right.

The Hoffman reflex was positive on the right side indicative of spinal cord compression. The deep tendon reflexes in the lower limbs were 2- to 3+. The Tinel's sign was positive on the right wrist. "Splitting of the ring finger" was noted on the left hand. The Phalen's test was bilaterally. The physician reviewed the MRI of the cervical spine and x-rays of the cervical spine. The physician reviewed the EMG/nerve conduction velocities of the upper extremities. The clinical impression was bilateral upper limb radiculopathy, degenerative disc disease of the cervical spine at multiple levels, stenosis centrally and foraminally at multiple levels, cervical spine spondylosis with evidence of myelopathy, and possible carpal tunnel syndrome. The physician opined at C5-6 and C6-7 there were long track signs causing symptoms. At C3-4 the injured worker harbored severe degenerative disc disease, which should be treated as the latter level is contributing to her neck pain and right shoulder pain. Authorization was requested for a C3-4, C5-6, and C6-7 anterior cervical discectomy and fusion and plating. There was a detailed Request for Authorization submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Anterior cervical discectomy and fusion at C3-4, using allograft and plating: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 180-181.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 179-181.

Decision rationale: The American College of Occupational and Environmental Medicine indicates that a surgical consultation may be appropriate for patients who have activity limitation for more than 1 month or with extreme progression of symptoms. There should be documentation of clear clinical, imaging, and electrophysiological evidence consistently indicating the same lesion that has been shown to benefit from surgical repair in both the short and long term. There should be documentation of unresolved radicular symptoms after receiving conservative treatment. The clinical documentation submitted for review indicated the injured worker had an EMG/NCV which revealed no findings at the requested levels. The x-rays of the cervical spine revealed disc degeneration at C3-4, C4-5, and C5-6. There was no abnormal translation on flexion and extension views. The injured worker had objective findings specifically noted at C6-7; however there was a lack of documentation of objective findings at the level of C3-4. Additionally, the requested level was 1 level and a fusion would not be necessary for the requested level. Given the above, and the lack of documentation indicating electrophysiologic evidence as well as clear clinical signs to support the necessity for surgical intervention at the level of C3-4, the request for anterior cervical discectomy using allograft and plating is not medically necessary.

Inpatient hospital stay (2 days): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), 11th Edition, 2013, Neck and Upper Back, Hospital Length of Stay

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.