

Case Number:	CM13-0010618		
Date Assigned:	12/11/2013	Date of Injury:	08/28/2008
Decision Date:	03/24/2014	UR Denial Date:	07/29/2013
Priority:	Standard	Application Received:	08/14/2013

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 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. 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 patient is a 44 year old male who sustained injury to his neck and lower back on 08/28/2008 while he was lifting heavy object. The injury prevented him returning to work and has become more symptomatic over the cervical spine area. The patient recently has had more severe exacerbation of his neck pain. Prior treatment has included cervical and lumbar epidural injections with not significant relief and physical therapy modalities and chiropractic treatment without relief. Diagnostic studies performed include MRI of the cervical spine. Spondylitic changes that are causing severe left neural foraminal stenosis at C5-C6 and advanced degenerative changes at C6-C7 with moderate neural foraminal stenosis consistent with the patient's complaints. EMG/NCV of the Bilateral Upper Extremity dated 09/28/2012 showed evidence of bilateral median demyelinating neuropathy across the wrists. Normal EMG study of the upper extremities. A clinic note dated 09/20/2013 showed the patient ambulated with the aid of a single point cane. The patient was observed to walk with a slight foot drop on the left. Patient was quite restricted in all ranges of motion of the cervical and lumbar spine secondary to pain and inability to properly balance on the left side. Diffuse tenderness to palpation over the paracervical spine, palpable trigger point noted about the left periscapular region. Cervical compression does not result in any radicular symptoms of the upper extremities; however, it does produce lower cervical and upper thoracic facet joint pain. Spine surgeon [REDACTED] recommends a single level anterior cervical discectomy and fusion at C5-C6. The patient's MRI does demonstrate significant spinal stenosis particularly left C6, which is consistent with the patient's complaint.

IMR ISSUES, DECISIONS AND RATIONALES

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

C5-C6 anterior cervical discectomy and fusion: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): s 181-183.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): s 181-183. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back (Acute and Chronic), Discectomy-laminectomy-laminoplasty & Fusion, anterior cervical.

Decision rationale: This patient complains of pain in her neck radiating down the left upper extremity. EMG/NCS of upper extremities showed bilateral carpal tunnel syndrome but normal EMG. Cervical MRI showed spondylotic changes with severe left neural foraminal stenosis at C5-6 and advanced degenerative changes at C6-7 with moderate neural foraminal stenosis. Exam dated 08/20/2013 showed tenderness over paracervical spine, more on the left and trigger point noted about the left periscapular region. Cervical compression did not produce radicular symptoms of the upper extremities other than lower cervical and upper thoracic facet joint pain. DTRs symmetrical bilaterally in upper extremities. Motor testing of upper extremities showed no weakness or deficits. As per ODG, "there must be evidence of radicular pain and sensory symptoms in a cervical distribution that correlate with the involved cervical level or presence of a positive Spurling test. There should be evidence of motor deficit or reflex changes or positive EMG findings that correlate with the cervical level." There are no sufficient findings documented to indicate the recommended surgery. There are no reflex changes and objective sensory or motor deficits documented and hence the request is non-certified.

1 day inpatient stay: 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), Neck and Upper Back (Acute and Chronic).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back (Acute and Chronic), Hospital length of stay (LOS).

Decision rationale: Without the approval for the surgery, 1 day inpatient stay is not medically necessary.