

Case Number:	CM13-0010809		
Date Assigned:	09/19/2013	Date of Injury:	11/04/2012
Decision Date:	01/03/2014	UR Denial Date:	07/17/2013
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, has a subspecialty in Spine 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.

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 51-year-old male who reported a work-related injury on 11/04/2012 as result of a motor vehicle accident. MRI of the cervical spine dated 01/16/2013 signed by [REDACTED] revealed: (1) multilevel spondyloarthropathy most advanced at C4-5 and C5-6; (2) developmental central canal spinal stenosis at all cervical levels; (3) acquired superimposed upon developmental central canal spinal stenosis was moderate at C4-5 and C5-6 where there was mild cord flattening, but no intramedullary signal abnormality to suggest cord edema or myelomalacia; (4) central canal spinal stenosis at C3-4 and C6-7 with cerebral spinal fluid effacement, but no cord flattening; (5) multilevel bony foraminal stenosis and facet arthrosis. The clinical note dated 06/27/2013 signed by [REDACTED] revealed an orthopedic spinal consultation and request for surgical authorization of the patient. The provider documents the patient's course of treatment since status post his work-related motor vehicle accident, the patient underwent injection therapy, physical therapy, and use of medication regimen. The patient reports constant moderate to severe stabbing pain with muscle spasms and stiffness to the cervical spine. The patient denied any radiating pain. The patient reported numbness and tingling down the bilateral upper extremities into the hands and fingers, right greater than left. On physical exam of the patient, the provider documented the patient had positive bilateral Spurling's sign. The patient had 5/5 motor strength noted throughout, 2/4 reflexes throughout the bilateral upper extremities, and negative Hoffmann's. The provider documented sensation was decreased to the bilateral C5, C6, and C7 dermatomes. Range of motion was noted as decreased to the cervical spine. The provider subsequently recommended emergent surgical treatment of the cervical spine as the patient reported having severe radiating arm pain and severe radiculopathy. The provider recommended a 3 level anter

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 C4-5, C5-6 and C6-7: Overturned

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 179-180.

Decision rationale: Spinal fusion per ACOEM guidelines is recommended for "Cervical discectomy with fusion is recommended for patients with subacute or chronic radiculopathy due to ongoing nerve root compression who continue to have significant pain and functional limitation after at least 6 weeks of time and appropriate non-operative treatment." The clinical documentation submitted for review evidences the patient continued to present with significant cervical spine pain complaints and radiation of pain to the bilateral upper extremities status post a work-related motor vehicle accident sustained on 11/04/2012. The patient utilized lower levels of conservative treatment to include cervical epidural steroid injections, physical therapy, and medication regimen without resolve of his symptomatology. Imaging study evidence of the patient's cervical spine revealed objective findings of mild spinal cord flattening at C4-5 and C5-6. The patient has continued to present with significant pain and functional limitation after at least 6 weeks of time and appropriate non-operative treatment; therefore, per ACOEM Guidelines, the request for anterior cervical discectomy and fusion C4-5, C5-6 and C6-7 is medically necessary and appropriate.