

Case Number:	CM13-0029886		
Date Assigned:	12/04/2013	Date of Injury:	02/20/2008
Decision Date:	03/24/2014	UR Denial Date:	09/09/2013
Priority:	Standard	Application Received:	09/25/2013

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 Spinal Surgery and is licensed to practice in New York. 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 female with a date of injury of February 20, 2008. The patient is diagnosed with neck sprain. Patient complains of severe pain in her neck radiating to her shoulders arm. She has had anterior cervical fusion and discectomy surgery at C5-C6. There is evidence of degenerative changes at C4-5 and C6-7. The patient has had conservative care including medications, a brace, and a bone stimulator. Treatment has included physical therapy. On physical examination she has tenderness to the cervical spine. There is reduced range of cervical motion. Discogram from August 2013 is fully concordant at C4-5 and concordant at C6-7. MRI from January 2013 shows 2 mm central disc protrusion at C3-4 causing mild effacement of the thecal sac. There is a 1.5 mm paracentral disc protrusion at C4-5 mildly indenting the anterior thecal sac. At C6-7 there is no indication of disc protrusion and no spinal stenosis. X-rays from June 2011 show a tear fusion at C5-6 with plate and screws and satisfactory alignment. There is no evidence of failure fusion. At issue is whether additional spine surgeries medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

ANTERIOR INSTRUMENTATION AT 2 TO 3 VERTEBRAL SEGMENTS OF THE CERVICAL SPINE: Upheld

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

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

Decision rationale: This patient does not meet established criteria set by the ACOEM guidelines are for cervical spine surgery. Specifically, the medical records do not indicate failure fusion and hardware failure, progressive neurologic deficit, spinal instability, fracture, or concern for tumor. There is no evidence of cervical instability warranting fusion. There is no evidence of progressive neurologic deficit warranting decompression. The patient's anterior spinal instrumentation surgery is not medically necessary based on the medical records. This patient has no findings of radiculopathy that clearly correlate with compression on MRI imaging studies. The patient does not have any imaging studies that demonstrate instability. Furthermore, the patient does not have any documented records that indicate failure fusion. The request for anterior instrumentation at 2 to 3 vertebral segments of the cervical spine is not medically necessary and appropriate.