

Case Number:	CM13-0035137		
Date Assigned:	12/13/2013	Date of Injury:	06/23/2008
Decision Date:	01/30/2014	UR Denial Date:	09/12/2013
Priority:	Standard	Application Received:	10/16/2013

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 Spine 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 48-year-old female with the date of injury of January 26, 2011. The patient was injured at work as a result of the cumulative trauma. The patient complains of severe neck pain which radiates to the bilateral shoulders and trapezii. She also gets headaches. Physical examination reveals normal cervical motion. Diagnoses include cervical strain, status post ACDF, cervical spondylosis C4-5, and C6-7 without stenosis. Patient also has bilateral carpal tunnel syndrome. Physical examination June 2013 reveals no gross motor abnormalities and some mild decreased sensation in the upper extremity. CT myelogram March 2013 revealed a disc bulge at C4-5 above the previous fusion of 2 mm. There is no central foraminal stenosis. C5-C6 demonstrates no solid fusion of the vertebral bodies. There is a 3 mm disc bulge impinging on the right C6 nerve root. At C6-7 there is disc space narrowing with a 2 mm disc bulge. There is no compression of the C7 nerve roots. Treatment has included activity modification, 22 physical therapy sessions, acupuncture, and a TENS unit. Diagnoses include C5-C6 pseudarthrosis. At issue is whether revision C5-C6 ACDF, C4-5 and C6-7 ACDF are needed.

IMR ISSUES, DECISIONS AND RATIONALES

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

Revision anterior cervical discectomy and fusion C4-5, C6-7: Upheld

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

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

Decision rationale: The patient does not meet MTUS criteria for cervical fusion at this time. While there is evidence of pseudarthrosis at C5-C6, there is no clear indication that the patient has corresponding motor, sensory, or reflex deficits in the adjacent C4-5 and C6-7 levels. There is no evidence on imaging studies of anatomic nerve root impingement at these adjacent levels. Therefore, fusion at the C4-5 and C6-7 levels is not medically necessary. There is no clinical correlation to justify the fusion of the digital 2 levels. Criteria for multilevel fusion anterior cervical surgery are not met at this time. Since the primary procedure is not medically necessary, none of the associated services are medically necessary.