

<b>Case Number:</b>	CM14-0167873		
<b>Date Assigned:</b>	10/15/2014	<b>Date of Injury:</b>	12/21/2012
<b>Decision Date:</b>	11/25/2014	<b>UR Denial Date:</b>	09/19/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/13/2014

### 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 Surgeon 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 50-year-old male who reported an injury on 12/21/2012. The mechanism of injury was cumulative trauma. The medications included Motrin 100 mg tablets, tramadol 50 mg tablets, ibuprofen 600 mg tablets, methocarbamol 500 mg, and Skelaxin 800 mg tablets. The injured worker was noted to have undergone an MRI of the cervical spine on 06/05/2013, which revealed there was mild disc degeneration with right paracentral posterolateral 2 mm disc protrusion at C4-5 causing moderate narrowing of the right lateral recess contact of the cervical cord without cord compression or central canal stenosis. At C3-4, there was moderate left uncovertebral hypertrophy and foraminal narrowing. At C2-3, there was right facet arthropathy and foraminal narrowing. At C5-6, there was mild degeneration, bulging, and bilateral foraminal narrowing. The surgical history was noncontributory. The documentation of 05/13/2014 revealed the injured worker had physical therapy, a TENS unit, and an epidural steroid injection. The physical examination revealed the injured worker had tenderness to palpation in the C3-5 region of the cervical spine. Motor strength was normal in the bilateral upper extremities. Sensation was grossly intact to the bilateral upper extremities except for the previously mentioned numbness in the right biceps region and going down the right finger and on the left side in the biceps area. In the upper extremities, the injured worker had lost a left sided biceps reflex, however still had a right sided biceps reflex. The Spurling's sign to the right reproduced pain and irritation going down the right arm, stopping at the biceps level. On the left, the physician documented it does not really bother the injured worker that much. The Spurling's sign did not bother the injured worker that much. The treatment plan included a new MRI and a C4-5 fusion and, potentially, a C3-4 fusion at the same time. There was no Request for Authorization submitted for the request procedure. The documentation of 09/11/2014 revealed the injured worker was recommended for electrodiagnostic studies to evaluate the numbness in

his hands and was recommended for cervical facet injections. The documentation indicated the injured worker had persistent neck pain. The diagnoses included cervical radiculopathy, right shoulder rotator cuff tendonitis, and cervicgia. The documentation indicated the injured worker had intermittent paresthesia in the hands (left greater than right) and had a positive Tinel's sign over the left hand. There was an agreement for electrodiagnostic studies of the bilateral upper extremities to evaluate the cause of the paresthesia and to make sure it was from cervical radiculopathy. A Request for Authorization was made for left C3-4, C4-5, and C5-6 facet joint injections for therapeutic and diagnostic purposes. There was no Request for Authorization submitted for the requested surgical intervention. There was no recent physical examination with findings submitted.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**C3-C5 anterior cervical discectomy and fusion:** Upheld

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

**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 failed to provide documentation of the official MRI and electrodiagnostic studies to support clear imaging and electrophysiological evidence of a lesion. There was a lack of documentation indicating the injured worker's response to the cervical facet injections. As such, there was a lack of documentation indicating a failure of conservative care. A fusion would be supported, if the discectomy was supported as it would create iatrogenic instability. However, given the above, the request for C3-C5 anterior cervical discectomy and fusion is not medically necessary.