

Case Number:	CM14-0172112		
Date Assigned:	10/23/2014	Date of Injury:	02/18/2004
Decision Date:	11/25/2014	UR Denial Date:	09/18/2014
Priority:	Standard	Application Received:	10/17/2014

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 02/18/2004. The mechanism of injury was not stated. The current diagnoses include C5-6 herniated nucleus pulposus with cord compression and neural foraminal stenosis, severe cervical spine pain, right C6 radiculopathy, T6-7 herniated nucleus pulposus with thoracic radiculopathy, L4-5 herniated nucleus pulposus with mild central stenosis and left sided neural foraminal narrowing, and severe chronic back pain with left greater than right leg pain. The injured worker was evaluated on 08/21/2014 with complaints of severe neck pain, mid thoracic pain, and lumbar spine pain. Previous conservative treatment includes medication management and lumbar epidural steroid injections. Physical examination revealed lateral neck and trapezius spasm; significant tenderness along the paraspinal muscles in the neck and low back; significantly reduced upper extremity strength with wrist extension on the left; mild bicep weakness on the left; decreased sensation along the left forearm; limited and painful cervical range of motion; an inability to flex the shoulders above horizontal secondary to neck pain and arm weakness; positive straight leg raising on the right; generalized weakness of the lower extremities; and decreased sensation in the left lower extremity. Treatment recommendations at that time included a lumbar epidural steroid injection at L4-5, and a C5-6 anterior cervical discectomy and fusion. A Request for Authorization form was then submitted on 09/08/2014. It is noted that the injured worker underwent an MRI of the cervical spine on 08/11/2014, which indicated focal central protrusion at C5-6, mildly flattening the cord without change in cord signal, and causing moderate central canal stenosis. The injured worker also underwent electrodiagnostic studies of the upper extremities on 08/19/2014, which indicated bilateral wrist median neuropathy at the carpal tunnel region.

IMR ISSUES, DECISIONS AND RATIONALES

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

C5-6 Anterior cervical discectomy and fusion: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 180, Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 179-180. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck & Upper Back Chapter, Fusion, Anterior cervical

Decision rationale: California MTUS/ACOEM Practice Guidelines state a referral for surgical consultation is indicated for patients who have persistent, severe, and disabling shoulder or arm symptoms; activity limitation for more than 1 month; clear clinical, imaging, and electrophysiologic evidence of a lesion; and unresolved radicular symptoms after receiving conservative treatment. The Official Disability Guidelines recommend an anterior cervical fusion for spondylotic radiculopathy or nontraumatic instability. There should be significant symptoms that correlate with physical examination findings and imaging reports. There should also be persistent or progressive radicular pain or weakness secondary to nerve root compression or moderate to severe neck pain despite 8 weeks of conservative therapy. There should be documented instability upon flexion and extension x-rays. As per the documentation submitted, the injured worker has been previously treated with injections and medications. However, there is no documentation of a recent attempt at conservative treatment in the form of active physical therapy or home exercise. There was no documentation of spinal instability upon flexion and extension view radiographs. Based on the clinical information received, the injured worker does not meet criteria for the requested procedure. As such, the request is not medically appropriate at this time.

L4-5 Transforaminal epidural steroid injection: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines epidural steroid injection Page(s): 46.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46.

Decision rationale: California MTUS Guidelines recommend epidural steroid injections as a possible option for short term treatment of radicular pain, with use in conjunction with active rehab efforts. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. Repeat blocks are based on continued objective documented pain and functional improvement. As per the documentation submitted, the injured worker has been previously treated with lumbar epidural steroid injections. There was no objective evidence of functional improvement. There was no documentation of 50% pain relief with an associated reduction of medication use for 6 to 8 weeks following the initial procedure. As such, the current request cannot be determined as medically appropriate.

Associated Surgical Service: Inpatient hospital stay x 2 days: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 180,Chronic Pain Treatment Guidelines.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: As the injured worker's surgical procedure has not been authorized, the current request is also not medically necessary.

Associated Surgical Service: Assistant surgeon: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 180,Chronic Pain Treatment Guidelines.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: As the injured worker's surgical procedure has not been authorized, the current request is also not medically necessary.

Associated Surgical Service: Pre-op evaluation: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 180,Chronic Pain Treatment Guidelines.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: As the injured worker's surgical procedure has not been authorized, the current request is also not medically necessary.

Associated Surgical Service: Inter-operative spinal cord monitoring: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 180,Chronic Pain Treatment Guidelines.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: As the injured worker's surgical procedure has not been authorized, the current request is also not medically necessary.