

Case Number:	CM14-0172245		
Date Assigned:	10/23/2014	Date of Injury:	05/21/2014
Decision Date:	12/03/2014	UR Denial Date:	10/02/2014
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 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 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 43-year-old male who reported an injury on 05/21/2014. The mechanism of injury was the injured worker was responding to an alarm, causing injury to his neck. The injured worker was certified a C5-6 and C6-7 anterior cervical discectomy and fusion with allograft and fixation using somatosensory and motor evoked potentials. The prior therapies were not provided. The diagnostic studies were not provided. Prior treatments were not provided. The documentation indicated the injured worker underwent a cervical MRI on 05/14/2014, which revealed mild disc height loss at C5-6 and C6-7 with bulging discs and a central protrusion at C5-6. There was a questionable small patchy T2 hyperintensity centrally within the cord distal to the disc protrusion at C5-6. The injured worker underwent a CT scan of the cervical spine on 06/20/2014, which revealed at C5-6 there was a central posterior disc protrusion narrowing that canaled to approximately 6.5 mm cranial to the disc osteophyte complex narrowing the canal to 7 mm. There was mild to moderate bilateral foraminal narrowing. At C6-7, there was mild posterior disc protrusion, central canal narrowing to 8.5 mm and mild foraminal narrowing. The injured worker was given a trigger point injection. The mechanism of injury was the injured worker fell on his face on concrete. The documentation of 09/25/2014 revealed the injured worker had right upper extremity weakness, numbness, pain and twitching along with left upper extremity tingling consistent with cervical myelopathy. The physician opined it was most likely due to cervical stenosis impinging upon the cord. The physician documented that he had reviewed the MRI of the cervical spine and the request was made for surgical intervention. There was a detailed Request for Authorization submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Possible adjacent segment surgery: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307.

Decision rationale: The American College of Occupational and Environmental Medicine indicate a surgical consultation may be appropriate for injured workers who have severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies preferably with accompanying objective signs of neural compromise. There should be documentation of activity limitations due to radiating leg pain for more than 1 month or the extreme progression of lower leg symptoms, and clear clinical, imaging and electrophysiologic evidence of a lesion that has been shown to benefit in both the short and long term from surgical repair and documentation of a failure of conservative treatment to resolve disabling radicular symptoms. The injured worker had myelomalacia on imaging and myelopathy on examination. There was a lack of documentation indicating clear electrophysiologic evidence to support the necessity for a possible adjacent segment surgery. Additionally, there was a lack of documentation of objective findings to support a necessity for an adjacent segment. If the injured worker remains symptomatic, there should be documentation of specific findings and rationale for the adjacent surgery. The request as submitted failed to indicate the level for the possible adjacent segment surgery. Given the above, the request for a possible adjacent segment surgery is not medically necessary.