

Case Number:	CM14-0026247		
Date Assigned:	06/16/2014	Date of Injury:	05/12/2003
Decision Date:	08/22/2014	UR Denial Date:	01/31/2014
Priority:	Standard	Application Received:	03/02/2014

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 Occupational Medicine 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:

Patient is a 53-year-old female who has submitted a claim for cervical radiculopathy, cervical spondylosis, and lumbar pain associated with an industrial injury date of 05/12/2003. Medical records from 2007 to 2014 were reviewed. Patient complained of neck pain radiating to bilateral upper extremities, associated with numbness and weakness. Physical examination showed painful cervical range of motion. Motor strength of 4/5 at right finger extensor, and grip strength of 4/5 at the left. Reflexes were normal. Sensation was diminished at C8 dermatome, bilaterally. X-ray of the cervical spine, dated 11/1/2013, demonstrated multi-level degenerative changes with minimal motion and no evidence for acute fracture. MRI of the cervical spine, dated 11/22/2013, showed a small right-sided bulge on C4-C5 and moderate bulge on right C5-C6, little foraminal disc at C6-C7 on the right and moderate protrusion on the left at C7-T1. Alignment abnormality was noted with straightening and overall reversal of the expected cervical lordosis with apex at C5. Multilevel degenerative changes with vertebral body height loss and anterior vertebral body spurring as well as osteophyte formation were seen. Treatment to date has included cervical epidural steroid injections, physical therapy, and medications. Utilization review from 01/31/2014 denied the prospective requests for anterior interbody fusion from C5-T1 and 2-3 day in-patient stay because there was no diagnostic imaging to support evidence of instability and there was no evidence of attempted epidural injections since 2008.

IMR ISSUES, DECISIONS AND RATIONALES

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

One Anterior Interbody Fusion from C5-T1: 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): 180. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck Section, Fusion, Anterior Cervical.

Decision rationale: The California MTUS ACOEM Practice Guidelines state that surgical consultation/intervention is indicated for patients who have persistent, severe, and disabling shoulder or arm symptoms, activity limitation for more than one month or with extreme progression of symptoms, clear clinical, imaging, and electrophysiology evidence, and unresolved radicular symptoms after receiving conservative treatment. In addition, Official Disability Guidelines states that criteria for anterior cervical fusion include severe pain or profound weakness of the extremities, x-ray findings of instability, MRI findings of cervical nerve root compression, and when requesting authorization for multiple levels, each level is subject to the criteria above. Recommendation is to limit to no more than three levels. In this case, patient complained of neck pain radiating to bilateral upper extremities. Appeal letter from 03/03/2014 cited that patient had weakness from C7 to T1 myotomes. MRI of the cervical spine from 11/22/2013 showed alignment abnormality with straightening and overall reversal of the expected cervical lordosis with apex at C5 and multilevel disc bulges. X-ray of the cervical spine, dated 11/1/2013, demonstrated multi-level degenerative changes with minimal motion abnormality. Reports cited that patient had tried and failed epidural steroid injections and physical therapy. However, MRI results did not meet guideline criterion for presence of nerve root compression. Given minimal MRI findings and lack of documented instability, indications for the proposed procedure are not established. Lastly, an electrodiagnostic study was not available, which may further corroborate the patient's manifestations. The medical necessity for a cervical fusion is not warranted at this time. Therefore, the request for One Anterior Interbody Fusion from C5-T1 is not medically necessary.

2-3 Day In-Patient Stay: Upheld

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

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

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.