MAXIMUS Federal Services

Case Number:	CM14-0031590		
Date Assigned:	06/20/2014	Date of Injury:	04/23/2012
Decision Date:	07/23/2014	UR Denial Date:	02/20/2014
Priority:	Standard	Application Received:	03/12/2014

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 Neurosurgery, 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 51-year-old was reportedly injured on June 18, 2011 as well as April 23, 2012 the mechanism of injury is noted as a lifting when the claimant attempted to transfer an obese patient from the bed to wheelchair. The most recent progress note dated January 31, 2014 indicates there are ongoing complaints of neck and left arm pain. The physical examination demonstrated Inspection: no paraspinal muscle atrophy, and ecchymosis, spasm, or deformity noted. Shoulder heights are symmetric. Range of motion: fluid, nontender, active and passive range of motion of the cervical spine in all planes including forward flexion, extension, rotation, and lateral bending. Pain noted on left lateral bending only. Palpation: nontender to the superficial and deep palpation along the axial spine, with tenderness and hypertonic left trapezius. Muscle strength bilateral upper extremities 5/5, Reflexes bilateral upper extremities 2+, Sensation: diminished sensation through the left index and middle finger. No other sensory defects noted in the C-3 toT-1 dermatomal distribution. Special tests: negative axial load test. Negative Sperling maneuver, Kerning Sign, Lhermitte sign, Hoffman signed bilaterally. Extremities: no focal findings on shoulder/elbow exam bilaterally. Capillary refill is brisk and normal distal radial pulses. Diagnostic studies include: Diagnostic imaging study (EMG/NCV) of the bilateral upper extremities performed on September 23, 2013 revealed an abnormal study. Evidence of a left C6-C7 radiculopathy. Also evidence of moderate bilateral carpal tunnel syndrome. No evidence of a right/left ulnar neuropathy, brachial plexopathy, or radial tunnel syndrome. There is also reference made of an MRI of the cervical spine dated October 24, 2011 that is quoted in the medical documents, however the official radiology report is not available for review. There is also mention of cervical spine x-rays dated October 27, 2011, however the official report is not available for review. Previous treatment includes: physical therapy, epidural steroid injection, medications to include Toradol, Voltaren, Naproxen, Ultram, and Baclofen. A

request had been made for Anterior Cervical Disc Fusion C6-7, and was not certified in the pre-authorization process on February 20, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Anterior Cervical Disc Fusion 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 Official Disability GuidelinesNeck And Upper Back Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), Cervical and Thoracic Spine.

Decision rationale: The Neck and Upper Back Complaints Chapter of the ACOEM Practice Guidelines does not reference anterior cervical discectomy and fusion. Therefore the ACOEM Practice Guidelines are used. Spinal fusion is recommended for sub-acute and chronic radiculopathy. Cervical discectomy with fusion is recommended for patients with subacute or chronic radiculopathy due to the ongoing nerve root compression who continue to have significant pain and functional limitation after at least six weeks of time and appropriate non-operative treatment. After reviewing the medical documentation provided it is noted that this 51-year-old male does have some radiculopathy noted in the left upper extremity with sensory deficits noted in the left index finger and left middle finger. Unfortunately there is no MRI report in the documentation, it is referenced in detail, but the original report is not available for review. The request for anterior cervical disc fusion C6-C7 is not medically necessary or appropriate.