

Case Number:	CM14-0048892		
Date Assigned:	06/25/2014	Date of Injury:	09/26/2006
Decision Date:	07/25/2014	UR Denial Date:	03/11/2014
Priority:	Standard	Application Received:	03/27/2014

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 Surgery, 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:

This 43-year-old sustained an industrial injury on September 26, 2006, due to heavy lifting. He was status post L4/5 instrumented fusion. The August 22, 2013 EMG/nerve conduction study documented a normal EMG (electromyography) of the upper and lower extremities. The nerve conduction study revealed peripheral polyneuropathy predominantly affecting sensory fibers secondary to a generalized/systemic neuropathic process. The February 26, 2014 secondary treating physician report cited 9/10 neck pain radiating into the bilateral trapezial region down the arms to the index fingers/thumbs. He complained of bilateral hand weakness and constant headaches. Cervical exam findings documented full range of motion, pain in cervical extension, normal motor strength, decreased C6 dermatomal sensation bilaterally, decreased brachioradialis reflexes bilaterally, and positive bilateral Spurling's test. The January 2, 2014 cervical MRI findings showed a C5/6 disc protrusion with significant foraminal stenosis. The C4/5 and C6/7 levels showed only mild neuroforaminal narrowing consistent with degenerative findings. The patient had failed appropriate conservative treatment including physical therapy, medication management, and cervical epidural steroid injection. An anterior cervical discectomy and fusion was recommended at the C5/6 level with associated services and durable medical equipment. The February 28, 2014 pain management report documented that the patient was a current smoker. The March 11, 2014 utilization review denied the request for the requested cervical fusion as there was no documentation that the patient had stopped smoking or that a psychosocial screen had been performed.

IMR ISSUES, DECISIONS AND RATIONALES

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

Anterior Cervical Discectomy and fusion C5-C6: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 166, 180-183. Decision based on Non-MTUS Citation Official Disability Guidelines, Treatment in Workers' Compensation 18th edition, 2013 Updates, Chapter Neck and Upper Back.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back, Discectomy-laminectomy-laminoplasty, Fusion, anterior cervical.

Decision rationale: California Medical Treatment Utilization Schedule guidelines do not address cervical fusion for chronic injuries. The Official Disability Guidelines recommend anterior cervical fusion as an option with anterior cervical discectomy if clinical indications are met. Surgical indications include evidence of motor deficit or reflex changes that correlate with the involved cervical level, abnormal imaging correlated with clinical findings, and evidence that the patient has received and failed at least a six to eight week trial of conservative care. Because of the high risk of pseudoarthrosis, a smoker anticipating a spinal fusion should adhere to a tobacco-cessation program that results in abstinence from tobacco for at least six weeks prior to surgery. Guidelines indicate that a psychological screen is optional prior to cervical surgery. Guideline criteria have not been met. Records indicate that the patient was continuing to smoke as of the February 28, 2014 progress report. Guidelines require abstinence from smoking for at least six weeks prior to surgery, which has not been met. Therefore, this request for anterior cervical discectomy and fusion at C5-C6 is not medically necessary or appropriate.