

Case Number:	CM14-0061825		
Date Assigned:	07/09/2014	Date of Injury:	07/29/2010
Decision Date:	08/21/2014	UR Denial Date:	04/28/2014
Priority:	Standard	Application Received:	05/02/2014

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 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 claimant is a 61-year-old male who sustained a vocational injury while working as a superintendent of commercial instruction on July 29, 2010 when he tripped over a conduit while working on a roof. The medical records provided for review document working diagnoses of moderate foraminal stenosis at C3-4 bilaterally and a compression fracture of the upper portion of C3 which is evident on CT scan. The report of an MRI dated February 5, 2013 showed an osteophyte and bulging complex at C2-3 causing 8 millimeters of stenosis in neutral and extension. There was 7 millimeters of spinal stenosis seen at the C3-4 level with 1 millimeter of retrolisthesis seen in extension only and the spinal canal narrowed to 6 millimeters. At C4-5 there was spinal canal stenosis of 8 millimeters in neutral. This improved to 9 millimeters in extension. There was no spinal canal stenosis seen at C5-6 in neutral and flexion. There was 9 millimeters stenosis seen in extension. Central disc protrusion was present. There was 9 millimeter of stenosis in extension at C6-7. The report of a CT scan from July 30, 2013 showed loss of lordosis of the cervical spine with patent neural foramina at C4-7, moderate foraminal stenosis at C3-4 bilaterally and a compression fracture of the upper portion of C3. The Psychologist's report dated October 4, 2013 noted that the claimant had a major depressive disorder and severe pain disorder and required eight additional individual sessions for depression and the pain disorder and recommended psyche testing once a month for one hour to track treatment response. The office note of April 15, 2014 noted that the claimant was depressed and under the care of a psychiatrist. Physical therapy with traction, one epidural steroid injection and acupuncture failed to provide any meaningful relief of the claimant's pain. The claimant utilized a home traction unit for relief as well as hydrocodone, Flexeril and soma. Objective findings on examination showed 5/5 strength in the bilateral upper extremities, a negative Hoffman's, reflexes were +1 at the biceps and triceps, and mild tenderness to palpation on the right side of

his neck at the lower cervical spine. The recommendation was made for a C3-4 anterior cervical discectomy and fusion.

IMR ISSUES, DECISIONS AND RATIONALES

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

2 Days length of stay: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck & 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); Treatment in Worker's Comp; 2013 Updates; Chapter Neck and Upper Back chapter, Hospital length of stay (LOS).

Decision rationale: The request for the C3-4 anterior cervical discectomy and fusion cannot be considered medically necessary. Therefore, the request for a two day inpatient stay is also not medically necessary.

C3-C4 anterior cervical discectomy and fusion: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and back.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 179-181. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Treatment in Worker's Comp; 2013 Updates; Chapter Neck and Upper Back chapter, Discectomy-laminectomy-laminoplasty.

Decision rationale: Based on the California ACOEM Guidelines and supported by the Official Disability Guidelines, the request for C3-C4 anterior cervical discectomy and fusion cannot be recommended as medically necessary. There is no documentation of an abnormal physical exam with objective findings suggesting there is significant radiculopathy and obvious instability at the requested level for surgical intervention in the cervical spine. In addition, the documentation also suggests the claimant is suffering from severe depression. The Official Disability Guidelines recommend that with a comorbidity such as depression, spinal fusion is typically not recommended until the psychiatric or psychological comorbidities can be better treated in an effort to ensure a better surgical outcome. Therefore, based on the documentation presented for review, and in accordance with California MTUS, ACOEM and Official Disability Guidelines, the request for the C3-4 anterior cervical discectomy and fusion cannot be considered medically necessary.

