

Case Number:	CM14-0073116		
Date Assigned:	07/16/2014	Date of Injury:	10/23/2013
Decision Date:	08/26/2014	UR Denial Date:	05/16/2014
Priority:	Standard	Application Received:	05/20/2014

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 Anesthesiology, has a subspecialty in Pain Management, 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 39 year old male whose date of injury is 10/23/13 when he was opening a door with no handle and the wind caught the door causing his left arm to hyperextend. The injured worker developed pain to the left shoulder, left trapezius, and feels like neck pain maybe. The injured worker was seen in orthopedic consultation on 01/21/14, with complaints of headaches; neck pain radiating to both sides left greater than right, associated with numbness and tingling in the left hand and fingers; left shoulder pain; mid back pain; low back pain; and insomnia. The injured worker was noted to have developed psychological trauma secondary to work-related injuries. Current medications were listed as Naproxen, Methocarbamol, Zantac, and Albuterol inhaler. The injured worker admits to tobacco use. X-rays of the cervical spine were noted to show 50% narrowing of C5-6 with spurs and degenerative disc disease. A thorough workup was recommended as well as a psychological consultation. Norco and Medrol DosePak were dispensed. Cervical MRI dated 02/07/14 showed multilevel changes with 2-3mm posterior disc protrusion at C3-4 and C4-5 with no compromise of the cord; at C5-6 there is 40% decrease in disc height; disc dehydration; 4-5mm posterior disc protrusion/extrusion with encroachment of the subarachnoid space; no compromise on the central ventral aspect of the cord; encroachment on the foramina bilaterally with acquired bilateral foraminal stenosis and compromise of the exiting nerve roots bilaterally; 4-5mm anterior disc protrusion; 2-3mm disc protrusion at C6-7 and C7-T1 with no compromise on the cord. Electrodiagnostic (EMG/NCV) dated 01/22/14 was a normal study. Per medical report dated 02/18/14 it was noted that the injured worker should go to physical therapy; needs to receive medications; needs epidural steroid injections of the cervical and lumbar spine; and needs consultation with a spine surgeon with possibility of doing cervical discectomy and fusion, and lumbar discectomy and fusion

IMR ISSUES, DECISIONS AND RATIONALES

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

Inpatient surgery: anterior cervical discectomy and fusion at C5-C6: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 179-181.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 179-183.

Decision rationale: ACOEM guidelines reflect that the efficacy of cervical fusion for patients with chronic cervical pain without instability has not been demonstrated. If surgery is a consideration, counseling and discussion regarding likely outcomes, risks and benefits, and especially expectations is essential. Patients with acute neck or upper back pain alone, without findings of serious conditions or significant nerve root compromise, rarely benefit from either surgical consultation or surgery. In this case there is no clear evidence of specific nerve root or spinal cord compromise/compression that would necessitate surgical intervention. Also, there is no comprehensive history of conservative measures completed to date for the cervical spine. The records do not indicate that the injured worker has undergone a presurgical psychological evaluation, even though the records indicate that the injured worker developed psychological trauma secondary to work-related injuries. Based on the clinical information provided, medical necessity is not established for Inpatient surgery: anterior cervical discectomy and fusion at C5-C6. The request is not medically necessary and appropriate.