MAXIMUS Federal Services

Case Number:	CM14-0214484		
Date Assigned:	01/07/2015	Date of Injury:	05/12/2014
Decision Date:	05/22/2015	UR Denial Date:	12/12/2014
Priority:	Standard	Application Received:	12/22/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: New York
Certification(s)/Specialty: Neurological Surgery

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 47-year-old female tripped and fell on a sidewalk on 5/12/2014, landing on her left shoulder. She sustained a contusion of her left shoulder, neck and knee/elbow. The progress note of 6/27/14 documents chiropractic treatment. Electrodiagnostic studies were obtained on 8/14/2014. The findings included fibrillation potentials in the left biceps muscle suggestive of C5/C6 radiculopathy. However, these findings were isolated and sampling of other muscles did not reveal denervation. In addition, there was evidence of a left sensory median neuropathy across the wrist. There was radicular pain going down the left arm and tingling in the thumb, index, and long finger. She completed 6 chiropractic sessions for the neck and 7 acupuncture sessions. The chiropractic treatment made her pain worse. An MRI scan of the cervical spine was obtained but was noted to be of poor quality. The axial cuts were not labeled. However, this did reveal a large extruded herniated disc at C6-7 on the left causing severe compression of the left C7 nerve root per progress notes. The herniated disc measured 5 mm in the AP dimension and 14 mm in the cranial caudal dimension. A CT/myelogram of the cervical spine dated 11/10/2014 revealed degenerative disc disease and narrowing at C3-4 through C6-7 interspaces. There was a mild posterior spondylotic ridging at C3-4 interspace without significant central spinal or lateral recess or foraminal stenosis. A 2-3 mm central disc osteophyte complex at C5-6 was noted with mild direct cord compression. However, there was no lateral recess or foraminal stenosis. A 3 mm left paracentral to left lateral soft herniated disc was noted at C6-7 interspace with minimal left-sided cord compression. This caused moderate left lateral recess and mild left foraminal stenosis. Straightening of the cervical spine was noted

probably related to pain and/or muscle spasm. The progress note of 11/21/2014 documents the herniation at C5-6 and C6-7. There was continuing neck pain and left-sided radicular pain. Sensation was decreased in the C6-7 dermatome on the left and the left triceps reflex was decreased. Recommendation was made for an anterior cervical discectomy and fusion at C5-6 and C6-7. A request for authorization for anterior cervical discectomy and fusion at C5-6 and C6-7 levels was noncertified by utilization review citing MTUS guidelines, particularly with regard to C5, C6 radiculopathy on the left. The reviewer opined that the EMG was not confirmatory for a left C5, C6 radiculopathy although fibrillation potentials were found in the biceps indicating denervation. According to the report, sampling of other muscles did not confirm this. Therefore, the guideline criteria of diagnostic corroboration of the radiculopathy were not met. The CT myelogram revealed a 2-3 mm herniation at C5-6 causing mild direct cord compression. There was a 3 mm left paracentral to left lateral soft disc herniation at C6-7 with minimal left-sided direct cord compression and moderate left lateral recess and mild left neural foraminal stenosis. The denial has now been appealed to an independent medical review.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Anterior Cervical Discectomy and Fusion at the C5-C6 and C6-C7 Levels: Overturned

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): 179, 180, 181.

Decision rationale: California MTUS guidelines indicate surgical considerations within the first 3 months of onset of work-related neck and upper back symptoms in the presence of severe spinal vertebral pathology, severe debilitating symptoms with physiologic evidence of specific nerve root or spinal cord dysfunction corroborated on appropriate imaging studies that did not respond to conservative treatment. Her disc herniation characterized by protrusion of the central nucleus pulposus through a defect in the outer annulus fibrosis may impinge on it nerve root causing irritation, shoulder and arm symptoms and nerve root dysfunction. However, the presence of a herniated disc on an imaging study does not necessarily imply nerve root dysfunction. Surgery 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 electrophysiologic evidence, consistently indicating the same lesion that has been shown to benefit from surgical repair in both the short and long-term, and unresolved radicular symptoms of after receiving conservative treatment. The clinical findings, the imaging studies, and the electrodiagnostic study corroborated the diagnosis of left C5 and C6 radiculopathy. Fibrillation potentials were seen in the biceps on the left representing evidence of denervation due to a C5 and C6 radiculopathy. There were sensory as well as motor symptoms and findings documented and deep tendon reflex changes and the diagnosis was confirmed by the imaging studies, which showed the left-sided herniation at C6-7 with probable nerve root impingement and also showed a midline herniation at C5-6 with mild direct cord compression. The guideline criteria have therefore been met and the request for anterior cervical

discectomy and fusion at C5-6 and C6-7 is supported and as such, the request is medically necessary.

Associated surgical service: 1 Assistant Surgeon: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Physicians as Assistants at Surgery 2011.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American Academy of Orthopedic Surgeons, Center for medicare and medicaid.

Decision rationale: The procedure qualifies for an assistant surgeon. The ODG guidelines indicate when the procedure is of sufficient seriousness, complexity in which the assistant thru his training and expertise can help, then his presence is medically necessary. The requested service is medically necessary and appropriate.

Associated surgical service: 14 Days of Post-Operative Home Health Nursing Visits for Wound Check and Dressing: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Home health services Page(s): 51.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Home health services Page(s): 51.

Decision rationale: Home health services are recommended only for patients who are home bound for otherwise necessary medical services. There is no indication that the injured worker will be home bound for 2 weeks. As such, the request for home health services for 2 weeks is not supported by guidelines and the medical necessity is not substantiated.

Associated surgical service: 3 Inpatient Hospital Days: 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), Treatment Index, 11th Edition (web), 2013, neck and upper back chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Section: Neck, Topic: Hospital length of stay.

Decision rationale: California MTUS guidelines do not address this issue. ODG guidelines indicate the Hospital length of stay for anterior cervical discectomy and fusion is median= 1 day, mean=2.2 days, Best practice target= 1 day (no complications).The request as stated for 3 days is not supported by guidelines and as such, it is not medically appropriate and necessary.