

Case Number:	CM15-0008457		
Date Assigned:	01/26/2015	Date of Injury:	07/30/2013
Decision Date:	03/26/2015	UR Denial Date:	12/17/2014
Priority:	Standard	Application Received:	01/14/2015

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: California

Certification(s)/Specialty: Orthopedic Surgery, Sports Medicine

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 61-year-old male who reported an injury on 07/30/2013 due to cumulative trauma while performing normal job duties. The injured worker's treatment history included physical therapy, medications, epidural steroid injections, and fusion surgery. The injured worker's diagnoses included status post C5-7 fusion with C3-5 junctional level pathology, and severe lumbar radiculopathy. The injured worker underwent an electrodiagnostic study on 11/07/2013. It was documented that the injured worker had peripheral neuropathy and bilateral L5 radiculopathy. The injured worker underwent a cervical MRI on 06/17/2013. It was documented that the injured worker had mild diffuse disc bulging at the C3-4 with severe left neural foraminal narrowing, a disc bulge at the C4-5 causing mild effacement of the ventral thecal sac, right neural foraminal narrowing at the C5-6, and evidence of an anterior fusion from the C5-7 with loss of the normal cervical lordosis. The injured worker was evaluated on 11/18/2014. It was documented that the injured worker had increasing radicular symptoms at the C3-4 and C4-5 levels. Physical findings at that examination included tenderness to palpation of the paravertebral musculature with limited range of motion. It was documented that the injured worker had hypersensitivity in the C4 distribution with numbness and tingling correlative of the C5 dermatomal pattern. The injured worker also had 4/5 strength in the deltoid biceps, and wrist extensors, consistent with C5-6 myotomal distributions. A request was made for a C3-5 anterior cervical discectomy and possible implantation of dynamic hardware with realignment of the junctional kyphotic deformity and reduction of listhesis. A Request for Authorization was submitted on 12/10/2014 to support the request.

IMR ISSUES, DECISIONS AND RATIONALES

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

C3-5 anterior cervical discectomy and possible implantation of dynamic hardware with re-alignment of junctional kyphotic deformity and reduction of listhesis: Overturned

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 upper back, Discectomy-laminectomy-laminoplasty

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178-180.

Decision rationale: The requested decision for C3-5 anterior cervical discectomy and possible implantation of dynamic hardware with re-alignment of junctional kyphotic deformity and reduction of listhesis is medically necessary and appropriate. The American College of Occupational and Environmental Medicine recommend fusion surgery in the presence of radicular symptoms that have failed to respond to conservative treatment and when there is evidence of instability. The clinical documentation does indicate that the injured worker has a previous fusion at the adjacent level. Any discectomy at the levels above the fusion would cause instability of the cervical spine and require fusion surgery. Given that the injured worker has failed to respond to conservative treatment and developed adjacent segment syndrome at the C3-4 and C4-5 levels, surgical intervention would be supported. As such, the requested C3-5 anterior cervical discectomy and possible implantation of dynamic hardware with re-alignment of junctional kyphotic deformity and reduction of listhesis is medically necessary and appropriate.