

Case Number:	CM15-0185826		
Date Assigned:	09/28/2015	Date of Injury:	02/02/2013
Decision Date:	11/09/2015	UR Denial Date:	09/14/2015
Priority:	Standard	Application Received:	09/21/2015

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: Minnesota, Florida

Certification(s)/Specialty: Orthopedic 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:

The injured worker is a 52 year old female, who sustained an industrial injury on 2-2-13. The injured worker was diagnosed as having chronic intractable axial neck pain; radiating bilateral shoulder pain, biceps pain, dorsal forearm pain; bilateral carpal tunnel. Treatment to date has included status post right carpal tunnel release (11-2013); physical therapy; acupuncture; medications. Diagnostics studies included MRI cervical spine (2-26-15); X-rays cervical spine (9-4-15). Currently, the PR-2 notes dated 7-29-15 indicated the injured worker complains of neck pain and stiffness. She reports no new symptoms or changes. She reports she has tried an epidural steroid injection and found no relief whatsoever. The provider notes "This was done about 2 weeks ago. She is very fearful of surgery still and some questions to think about in terms of surgery. Medications: Diclofenac 100mg twice a day, Gabapentin 600mg daily, and Protonix 20mg twice a day." The provider documents a cervical spine examination: "Inspection: No obvious deformities, normal cervical lordosis. No scars, No skin changes. No ecchymosis noted. No shoulder asymmetry noted. She has a right wrist incision that is well-healed. Palpation: She has tenderness to palpation of the low cervical region and also in the bilateral trapezius region with palpable spasms in the right trapezius. Her neurological examination" Equivocal weakness in the biceps, wrist extension, and wrist flexion which I would rate as 4+ out of 5 but otherwise 5 out of 5." He reviews her diagnostic studies and documents a Cervical Spine MRI dated 2-26-15 "shows cervical spondylosis with disc osteophyte complex notable at C5-6 and loss of disc height and degenerative changes at C5-6 with mild-to-moderate effacement of the anterior aspect of the dura and mild-to-moderate bilateral neural foraminal narrowing." The provider documents he had a lengthy discussion with the injured worker regarding an anterior cervical discectomy and fusion at C5-6 where she has known cervical spondylosis. He explained the

risks and benefits with indications and expected recovery. She will take all into consideration. A RP-2 note dated 7-29-15 from her primary treating physician documents the injured worker saw the surgeon on 7-29-15 and he recommended cervical spine surgery. He notes she complains of constant cervical spine pain and stiffness with radiating thoracic spine and lumbar spine pain and stiffness. She complains of bilateral upper extremity numbness to hand right greater than left. On examination, the provider notes positive tender to palpation of the cervical spine left greater than right with positive spasms. She also has decreased sensation to the bilateral upper extremities and positive spasms in the thoracic spine. His treatment plan notes failed conservative therapy for the cervical spine including physical therapy, home exercise program, cervical epidural steroid injection x1 with no help and medications. The surgeon has indicated surgery - ACDF C5-6. The provider agrees with the surgeon's findings and is requesting the authorization for the cervical ACDF C5-6 surgery. PR-2 dated 7-22-15 indicated the injured worker complained of some interval loss of strength in recent weeks with persistent pain and dysesthesias in both forearms and hands. She experiences a substantial degree of numbness and tingling in her hands with poor dexterity. She does appreciate a modest degree of symptoms stabilization and improved capacity to perform activities of daily living with use of the provided medications. A Request for Authorization is dated 9-21-15. A Utilization Review letter is dated 9-14-15 and non-certification was for a Anterior cervical discectomy and fusion, C5-6. A request for authorization has been received for Anterior cervical discectomy and fusion, C5-6.

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, C5-6: Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Surgical Considerations.

Decision rationale: Per progress notes dated July 29, 2015, the injured worker is a 52-year-old female (██████████) with a date of injury of February 2, 2013. She was complaining of neck pain and stiffness. She had no relief from the epidural steroid injection given 2 weeks prior. She was very fearful of surgery and had some questions to think about in terms of surgery. On examination she was tender to palpation in the lower cervical region and bilateral trapezius region with palpable spasm in the right trapezius. On neurologic examination, there was equivocal weakness in the biceps, wrist extension, and wrist flexion rated 4+/5. No sensory deficit was documented. No objective neurological findings pertaining to deep tendon reflexes were documented. The MRI scan of the cervical spine dated February 26, 2015 was unofficially said to show cervical spondylosis with disc osteophyte complex notable at C5-6 and loss of disc height and degenerative changes at C5-6 with mild to moderate effacement of the anterior aspect of the dura and mild to moderate bilateral neural foraminal narrowing. A prior progress report of 7/22/2015 had documented subjective complaints of numbness and tingling in her hands with poor dexterity with a modest degree of symptom stabilization and improved capacity to perform activities of daily living. She had undergone a right carpal tunnel release in 2013. On examination focal tenderness was present over both carpal tunnels as well as proximally in the forearms. There was localized tenderness over the right cubital tunnel and also in the right supraclavicular fossa. Tinel's, Phalen's, and Durkan's signs remained positive bilaterally as well as pressure provocative testing over the pronator tunnel on both sides and cubital compression

test on the right side. Roos sign was positive on the right (this implies the possibility of thoracic outlet syndrome). Spurling sign was negative. An EMG and nerve conduction study dated August 19, 2014 was reported as showing no electrodiagnostic evidence of bilateral upper extremity localized median, ulnar, or radial sensory or motor neuropathy, and no electrodiagnostic evidence of cervical axonal motor radiculopathy or brachial plexopathy. However, the results did not exclude the possibility of cervical sensory radiculitis. Based upon the documented findings in these progress notes, particularly indicating absence of a Spurling test, absence of objective neurologic deficit, and absence of electrodiagnostic evidence of radiculopathy and mild to moderate neural foraminal narrowing on the MRI scan, and the lack of improvement with an epidural steroid injection at C5-6 indicating that the diagnosis may be in doubt, the request for an anterior cervical discectomy and fusion at C5-6 is not supported. California MTUS guidelines indicate referral for surgical consultation 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 and 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 after receiving conservative treatment. In this case, the diagnosis is clearly in doubt for reasons discussed. The clinical examination, the MRI findings, and the electrodiagnostic testing do not indicate the same lesion that has been shown to benefit from surgical intervention. As such, the surgical request is not supported and the medical necessity of the request has not been substantiated.