MAXIMUS Federal Services

Case Number:	CM15-0196999		
Date Assigned:	10/12/2015	Date of Injury:	07/08/2014
Decision Date:	11/30/2015	UR Denial Date:	09/16/2015
Priority:	Standard	Application Received:	10/06/2015

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 61 year old male, who sustained an industrial injury on 7-8-14. The injured worker was diagnosed as having severe cervical disc degeneration with bulging C4-C7, cervical stenosis; cervical spondylosis. Treatment to date has included physical therapy; status post cervical facet nerve block C4-C7 (7-17-15); medications. Diagnostics studies included MRI cervical spine (8-21-15). Currently, the PR-2 notes dated 9-3-15 indicated the injured worker presented to the office for a follow-up visit. He complains of neck pain, bilateral shoulder pain, bilateral arm pain and headaches. The injured worker reports his symptoms are getting worse. The provider notes a recent cervical spine MRI "does show multiple levels cervical degenerative disc disease and stenosis." His treatment plan includes an "ACDF C3-C7" and "bone marrow aspiration." On physical examination the provider notes "cervical tenderness, mild grip weakness left; decreased left C6 sensation; absent left BJ; no cerebellar signs; gait normal." The injured worker has a "Bilateral Cervical Facet Block at C4-C7 under fluoroscopic guidance" on 7-17-15. The notes do not document benefit from this procedure. A Request for Authorization is dated 9-30-15. A Utilization Review letter is dated 9-16-15 and non-certification for Anterior cervical discectomy, fusion, C3-C4, C4-C5, C5-C6, C6-C7. A request for authorization has been received for Anterior cervical discectomy, fusion, C3-C4, C4-C5, C5-C6, C6-C7.

IMR ISSUES, DECISIONS AND RATIONALES

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

Anterior cervical discectomy, fusion, C3-C4, C4-C5, C5-C6, C6-C7: Upheld

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

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

Decision rationale: The injured worker is a 61-year-old male with a date of injury of 7/8/2014. The mechanism of injury was a blow to the head from a broken handrail that he was welding that fell and struck him on the hard hat. The subjective complaints included headaches and neck pain, arm pain and paresthesias in the upper extremities. There is a history of cancer and hypertension in the past. The current issues pertain to the cervical spine. The imaging studies include an MRI scan from 8/21/2015 which showed scoliosis in the lower cervical spine and multiple level degenerative disc disease. At C3-4 there was a wide based protrusion that measured 4 mm anteroposteriorly associated with an annular fissure. There was flattening of the anterior contour of the cord. Facet hypertrophy was noted. There was bilateral neural foraminal stenosis resulting from the uncinate hypertrophy, marginal osteophyte formation and facet hypertrophy associated with disc protrusion. The C4-5 level demonstrated wide based disc protrusion measuring up to 3 mm AP, facet hypertrophy and moderate to severe bilateral neural foraminal stenosis. The C5-6 level demonstrated wide based disc protrusion measuring up to 3 mm AP on the left, 5 mm AP in the center and 6 mm AP on the right. There was indentation on the anterior contour of the cord on the right and centrally. The AP diameter of the central thecal sac was 9 mm and right paracentral was 8 mm. Facet hypertrophy was seen bilaterally. There was right and left lateral leg tension of the disc protrusion, more so towards the right and there was severe right and moderate to severe left neural foraminal stenosis. Progress notes dated 9/3/2015 document subjective complaints of neck pain, bilateral shoulder pain, bilateral arm pain and headaches. On examination there was cervical tenderness, mild weakness of grip on the left, decreased sensation in the left C6 dermatome, absence of left biceps jerk and a normal gait with no cerebellar signs. The plan was C3-C7 anterior cervical discectomy and fusion. The documentation does not indicate a preoperative psychological evaluation. He was status post facet joint blocks which helped for a few days. Additional notes dated August 5, 2015 document a history of neck pain and bilateral shoulder pain and headaches but there is no documentation of arm pain. Physical findings were similar to the findings of 9/3/2015. The California MTUS guidelines indicate referral for surgical consultation for patients who have persistence, 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 after receiving conservative treatment. It would also be prudent to consider a psychological evaluation of the patient prior to referral for surgery. In this case, the clinical examination documents hypoesthesia in the C6 distribution on the left. The biceps reflex is absent on the left. This would indicate C5 and C6 nerve root involvement. However, the procedure requested is a 4 level fusion. There is no electrophysiologic evidence of radiculopathy that corroborates the MRI findings. Furthermore, a psychological evaluation suggested by guidelines has not been performed. In light of the foregoing, particularly the absence of a psychological evaluation prior to a 4 level fusion, the request as stated for anterior cervical discectomy and fusion C3-7 is not supported and the medical necessity of the request has not been substantiated.