

Case Number:	CM14-0134115		
Date Assigned:	08/25/2014	Date of Injury:	04/16/2010
Decision Date:	10/08/2014	UR Denial Date:	07/31/2014
Priority:	Standard	Application Received:	08/18/2014

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 Orthopedic Surgery 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 59-year-old male who reported an injury on 04/16/2010 due to cumulative trauma while performing normal job duties. The injured worker reportedly sustained an injury to his cervical and lumbar spine. The injured worker's treatment history included physical therapy, immobilization, acupuncture, medications, a home exercise program, and epidural steroid injections. The injured worker underwent a cervical MRI on 10/23/2012 that documented (1) there was a disc bulge at the C7-T1 without central or lateral spinal stenosis, a disc bulge at the C6-7 with moderate central canal narrowing, and moderate left and mild to moderate right neural foraminal narrowing; (2) a disc bulge at the C5-6 with severe central canal narrowing and moderate to severe bilateral neural foraminal narrowing; (3) a 4 mm disc bulge with moderate to severe left sided central canal narrowing and severe left and moderate right neural foraminal narrowing at the C4-5, and a disc bulge at the C3-4 with severe central canal narrowing and severe left and moderate right neural foraminal narrowing. The injured worker underwent a lumbar MRI on 10/23/2012 that documented (1) there was a disc bulge at the L1-2 with left sided compression of the thecal sac, a disc bulge at the L3-4 without central canal or lateral spinal stenosis, an anterolisthesis at the L4 on the L5 with severe bilateral facet hypertrophy and moderate to severe transverse narrowing of the central canal; (2) and a disc bulge with mild central canal narrowing at the L5-S1. The injured worker underwent an electrodiagnostic study of the upper extremities on 02/23/2013 that documented there was chronic left sided C6 radiculopathy, possible chronic right C7 radiculopathy, and evidence of carpal tunnel syndrome bilaterally. The injured worker was evaluated on 06/24/2014. It was documented that the injured worker had persistent lumbar and cervical spine pain complaints. Objective findings included tenderness to palpation of the cervical paraspinal musculature and upper trapezial musculature with numbness and tingling to the 1st through 4th fingers along the

C6, C7, and C8 dermatomal distributions with restricted range of motion secondary to pain. Evaluation of the lumbar spine documented tenderness to palpation over the lumbar paraspinal musculature and sacroiliac joint junction with decreased sensation in the L5-S1 distribution and a positive straight leg raising test. It was noted that the injured worker had decreased range of motion of the lumbar spine secondary to pain. The injured worker's diagnosis included cervical central canal stenosis. The injured worker's treatment plan included cervical spine surgery followed by lumbar spine surgery due to abnormal physical examination findings and a failure to improve with conservative treatment. A Request for Authorization Form was submitted on 06/25/2014 to support the request.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cervical spine surgery followed by lumbar surgery with unknown inpatient length of stay:
Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints, Chapter 12 Low Back Complaints Page(s): 179-180; 306-307.

Decision rationale: The requested cervical spine surgery followed by lumbar surgery with unknown inpatient length of stay is not medically necessary or appropriate. The American College of Occupational and Environmental Medicine recommends cervical and lumbar spine surgery for patients who have clinically evident radiculopathy that has failed to respond to conservative treatment and is correlative of pathology identified on an imaging study. The clinical documentation submitted for review does indicate that the patient has persistent radicular symptoms in both the lumbar and cervical regions that have not responded to conservative treatments. However, the request as it is submitted does not specifically identify the type of surgery being requested for either the cervical or lumbar spine. Due to the vagueness of the request and the Request for Authorization Form submitted on 06/24/2014, the appropriateness of the request itself cannot be determined. As such, the requested cervical spine surgery followed by lumbar surgery with unknown inpatient length of stay is not medically necessary or appropriate.

Follow-up visit in five to six weeks to review response to treatment: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

