

Case Number:	CM14-0170682		
Date Assigned:	10/23/2014	Date of Injury:	07/23/2009
Decision Date:	11/25/2014	UR Denial Date:	10/09/2014
Priority:	Standard	Application Received:	10/15/2014

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 Spine Surgery, and is licensed to practice in Texas. 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 64-year-old male who reported an injury on 07/23/2009. While moving washers and dryers, he felt pain in his mid-back and thoracic area. There were no diagnoses reported. Past treatments were chiropractic sessions, physical therapy, a cervical epidural steroid injection, and 2 thoracic epidural steroid injections. Also, the injured worker has had psychological care. MRI of the cervical spine dated 12/30/2013 revealed an area of slight abnormality within the cervical cord to the right of the midline of the C2-3 seen on the sagittal STIR images. This may be artifact; further views are required. At C3-4 there was "mild disc desiccation in 1 mm to 2 mm broad based disc bulge" indenting the anterior cord. That, along with congenital short pedicles, was causing mild to moderate spinal stenosis. At the C4-5, there was mild disc desiccation and a 2 mm broad based disc bulge indenting the anterior cord. Again, congenitally short pedicles were described causing mild spinal stenosis. There was moderate bilateral neural foraminal narrowing documented. There was also mild bilateral facet degenerative changes present. At C5-6, there was severe disc narrowing. There was a 2 mm to 3 mm broad based disc osteophyte complex indenting the anterior cord. There were, again, congenital short pedicles causing mild to moderate stenosis, and a severe right and moderate to severe left neural foraminal narrowing documented. There were mild bilateral facet degenerative changes. At C6-7 there was mild disc desiccation and disc space narrowing noted. There was a right paracentral 2 mm protrusion indenting the anterior cord with mild narrowing of the right side of the canal. There was mild right neural foraminal narrowing, but no left neural foraminal narrowing. Based on the heterogeneous thyroid gland, an ultrasound of that organ was recommended. Surgical history was not reported. There was no physical examination submitted for review. Medications were not reported. Treatment plan, rationale, and request for authorization were not submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

C4-5, C5-6, C6-7 anterior cervical spine discectomy fusion with instrumentation and 2 day inpatient stay: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 179-181.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 179-180.

Decision rationale: The decision for C4-5, C5-6, C6-7 anterior cervical spine discectomy fusion with instrumentation and 2 day inpatient stay is not medically necessary. Within the first three months of onset of potentially work-related acute neck and upper back symptoms, consider surgery only if the following are detected: Severe spinovertebral 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 therapy; a disk herniation, characterized by protrusion of the central nucleus pulposus through a defect in the outer annulus fibrosis, may impinge on a nerve root, causing irritation, shoulder and arm symptoms, and nerve root dysfunction. The presence of a herniated cervical or upper thoracic disk on an imaging study, however, does not necessarily imply nerve root dysfunction. Studies of asymptomatic adults commonly demonstrate intervertebral disk herniations that apparently do not cause symptoms. Referral for surgical consultation 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; unresolved radicular symptoms after receiving conservative treatment. There must be evidence that the patient has received and failed at least a 6-8 week trial of conservative care. The MRI report dated 12/30/2013 does not indicate spondylolisthesis of the cervical spine. There was moderate bilateral neuroforaminal narrowing. At C6-7 there was severe disc narrowing. There was no physical examination submitted to corroborate radiculopathy. There were no neurological deficits with strength, sensation, or reflexes suggestive of radiculopathy reported. Also, it was not noted that the injured worker had severe and disabling shoulder or arm pain. Based on the clinical information submitted for review, this request for anterior cervical fusion with instrumentation is not medically necessary.