

Case Number:	CM14-0201255		
Date Assigned:	12/11/2014	Date of Injury:	02/02/2012
Decision Date:	02/09/2015	UR Denial Date:	11/14/2014
Priority:	Standard	Application Received:	12/02/2014

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 Minnesota. 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 58-year-old male with a reported date of injury of 02/02/2012. The mechanism of injury was working overhead with a knife. The diagnosis is cervical spinal stenosis. The injured worker developed some neck and left shoulder pain. He received multiple steroid injections to the left shoulder and physical therapy. He also complained of pain radiating from the cervical spine down both upper extremities into the hands and the middle 3 fingers. The shoulder diagnosis was calcific tendinitis of the left shoulder. A cervical MRI dated 10/8/2012 revealed moderate to severe degenerative disc disease at C5-6 with posterior bony bar formation causing mild to moderate central canal stenosis, mild flattening of the anterior border of the cervical cord and bilateral osseous foraminal stenosis. Mild to moderate degenerative facet arthrosis was noted at C4-5 with slight grade 1 anterolisthesis of C4 on C5. Mild posterior bony bar formation was noted at C3-4 with left sided uncovertebral spur causing moderate to severe left neural foraminal stenosis and partial effacement of the left lateral recess at that level. An MRI scan of the cervical spine dated 6/27/2014 is noted. The impression was moderate posterior osteophyte formation and disc protrusion at C5-6 diffusely with mild spinal stenosis and bilateral neural foraminal narrowing unchanged from 10/8/2012. There was a left posterolateral osteophyte formation and disc protrusion at C3-4 with neural foraminal narrowing on the left. There was slight degenerative anterolisthesis at C4-5. The most recent MRI of the cervical spine with 3-D reconstruction is dated 10/17/2014. This revealed spondylotic degenerative changes at multiple levels, most pronounced at C5-6. At C5-6 there was disc narrowing, marginal spurring, 3.5 mm of broad-based disc osteophyte complex, some thickening of ligamentum flavum and there was cord contact, flattening of the cord, and midline AP canal stenosis of 7.5 mm and there was moderate to high-grade bilateral foraminal narrowing. At C3-4 3 millimeter of disc osteophyte complex was eccentric to the left and there was no central canal

stenosis but there was mild to moderate bilateral foraminal narrowing. At C4-5 only 1 mm of annular disc bulging was noted without central canal stenosis. A follow-up neurosurgical consultation of 10/21/2014 is noted. Range of motion of the cervical spine was very restricted secondary to pain. He was holding his head a bit to the left in some flexion. He was tender in the midline in the cervical area and over the left trapezius area and suprascapular area. He could not abduct his shoulder beyond 90 secondary to pain and stiffness. He had some balance difficulties and had to hold onto the exam table when walking on tiptoes and on heels. Grip strength was 3/5 on the left, decreased sensation over the left lateral forearm and decreased strength of the deltoid and biceps to 2/4 on the left. Deep tendon reflexes were symmetrical and 3/4 in the upper and lower extremities. No clonus was noted. Spurling sign was negative bilaterally. MRI and x-rays were reviewed. The diagnosis was severe cervical central canal stenosis with signs of myelopathy on physical exam. Daily nicotine use is documented. A request for a two-level anterior cervical discectomy and fusion at C4-5 and C5-6 with plate application was noncertified by utilization review citing lack of conservative treatment such as therapy or epidural steroid injections. The denial is now appealed to an IMR.

IMR ISSUES, DECISIONS AND RATIONALES

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

Anterior Cervical Discectomy & Fusion at C4-5 and C5-6 with Plate Application: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 179, 180, 183.

Decision rationale: California MTUS guidelines indicate surgical considerations for 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. Surgical consideration is indicated for 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. There is evidence of spinal stenosis at C5-6 with associated bilateral neural foraminal narrowing and flattening of the cord at that level. Based upon the clinical picture as well as the imaging studies, the medical necessity of an anterior cervical discectomy and fusion at C5-6 is substantiated. However, the request as stated also includes a similar procedure at C4-5. The documentation submitted does not support anterior cervical discectomy and fusion at C4-5. The MRI findings indicate 1 mm of annular bulge at C4-5 and very minor posterolateral spurring without cord contact or central canal stenosis and only mild foraminal narrowing. These changes certainly do not warrant a fusion at that level. There is no electrophysiologic evidence of radiculopathy at that level. In light of the above, the request for anterior cervical discectomy and fusion at C4-5 is not supported. Based upon the above guidelines, the request for anterior cervical discectomy and

fusion at C4-5 and C5-C6 with plate application is not supported and as such, the medical necessity of the request is not substantiated.

Associated surgical service: 1 day inpatient stay: 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.

Associated surgical service: pre-operative medical clearance: 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.