Case Number:	CM13-0019769		
Date Assigned:	12/11/2013	**Date of Injury:**	06/17/2011
Decision Date:	02/13/2014	**UR Denial Date:**	08/22/2013
Priority:	Standard	**Application Received:**	09/03/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Orthopedic Surgery, has a subspecialty in Fellowship trained in Spine 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 physician 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:

This patient is a 47-year-old male with a reported date of injury of 06/17/2010 to 06/17/2011. The mechanism of injury is described as continuous trauma started during his course of employment. He was seen in clinic on 08/12/2013 and at that time was taking gabapentin, Senna-docusate, Senokot, tizanidine, hydrocodone, and was using Butrans patches. He complained of constant pain to his neck that was radiating down his arms with associated numbness and tingling. On evaluation of his right upper extremity, he had positive Neer and Hawkins signs to his right shoulder as well as to his left shoulder. In regard to his right wrist, he had sensory deficit to light touch over the hand in all 5 fingertips, right side greater than left. He returned to clinic on 11/06/2013 and apparently still continued to report neck pain. He had associated numbness and tingling to the bilateral upper extremities. Diagnosis included cervical neck pain with radiculopathy. The plan going forward was to proceed with a C5-6 and C6-7 cervical spine anterior discectomy with use of an allograft cage spacer, local bone, and anterior plating.

IMR ISSUES, DECISIONS AND RATIONALES

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

Assistant Surgeon: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation the American Association of Orthropaedics Surgeons Position Statement Reimbursement of the First Surgeryin Orthropaedics.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Surgeons, Physicians as Assistants at Surgery 2011.

Decision rationale: The submitted records do not include objective evidence of imaging studies to document objectively that there is pathology to the cervical spine. The American College of Surgeons, Physicians as Assistants at Surgery, 2011, states, "In general, the more complex or risky the operation, the more highly trained the first assistant should be. Criteria for evaluating the procedure include: anticipated blood loss; anticipated anesthesia time; anticipated incidence of intra-operative complications; procedures requiring considerable judgmental or technical skills; anticipated fatigue factors affecting the surgeon and other members of the operating team; procedures requiring more than one operating team. In limb reattachment procedures, the time saved by the use of two operating teams is frequently critical to limb salvage. It should be noted that reduction in costly operating room time by the simultaneous work of two surgical teams can be cost effective." As the objective evidence documenting pathology to the cervical spine has not been provided for this review, and a psychological evaluation clearing this patient for surgery has not been documented, there were be no need for an Assistant Surgeon at this time. The request is non-certified

PRE-OP MEDICAL DIAGNOSTIC TESTING WITH H&P: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) low back chapter, Pre-op testing.

Decision rationale: The Official Disability Guidelines indicate that "An alternative to routine preoperative testing for the purpose of determining fitness for anesthesia and identifying patients at high risk of postoperative complications may be to conduct a history and physical examination, with selective testing based on the clinician's findings. However, the relative effect on patient and surgical outcomes, as well as resource utilization, of these 2 approaches is unknown." The records at this time do not indicate that the surgery has been certified and therefore there would be no need for preoperative testing. This request for Pre-Op Medical Diagnostic Testing With H&P is non-certified.

C5-6-C6-7 ANTERIOR CERVICAL DISKECTOMY FUSION INSTRUMENATION: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation CA MTUS, American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition, Neck and Upper Back Complaints, Chapter 7- Independent medical Examinations and Consultations.

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

Decision rationale: MTUS/ACOEM, chapter 8, states "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. The efficacy of cervical fusion for patients with chronic cervical pain without instability has not been demonstrated. If surgery is a consideration, counseling and discussion regarding likely outcomes, risks and benefits, and especially expectations is essential. Patients with acute neck or upper back pain alone, without findings of serious conditions or significant nerve root compromise, rarely benefit from either surgical consultation or surgery. If there is no clear indication for surgery, referring the patient to a physical medicine and rehabilitation (PM&R) specialist may help resolve symptoms. Based on extrapolating studies on low back pain, it also would be prudent to consider a psychological evaluation of the patient prior to referral for surgery. Many patients with strong clinical findings of nerve root dysfunction due to disk herniation recover activity tolerance within one month; there is no evidence that delaying surgery for this period worsens outcomes in patients without progressive neurologic findings. Spontaneous improvement in MRI-documented cervical disk pathology has been demonstrated with a high rate of resolution. Surgery increases the likelihood that patients will have to have future procedures with higher complication rates. A 12% reoperation rate was reported in one large series. Patients with comorbid conditions, such as cardiac or respiratory disease, diabetes, or mental illness, may be poor candidates for surgery. Comorbidity can be judged and discussed carefully with the patient... patients with radiation of pain to the arm(s) and hand(s) had better relief of pain with surgery than those with neck pain alone. Pre-surgical screening should include consideration of psychological evaluation." The records do not include a psychological evaluation as recommended by MTUS/ACOEM and do not include imaging studies to objectively document pathology to the cervical spine as recommended by MTUS/ACOEM. Therefore, this request for C5-6-C6-7 Anterior Cervical Diskectomy Fusion Instrumenation is not medically necessary at this time and is non-certified.

Anterior Cervical Discectomy with Interbody Fusion: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) neck chapter, cervical fusion.

Decision rationale: MTUS/ACOEM, chapter 8, states "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. The efficacy of cervical fusion for patients with chronic cervical pain without instability has not been demonstrated. If surgery is a consideration, counseling and discussion regarding likely outcomes, risks and benefits, and especially expectations is essential. Patients with acute neck or upper back pain alone, without findings of serious conditions or significant nerve root compromise, rarely benefit from either surgical consultation or surgery. If there is no clear indication for surgery, referring the patient to a physical medicine and rehabilitation (PM&R) specialist may help resolve symptoms. Based on extrapolating studies on low back pain, it also would be prudent to consider a psychological evaluation of the patient prior to referral for surgery. Many patients with strong clinical findings of nerve root dysfunction due to disk herniation recover activity tolerance within one month; there is no evidence that delaying surgery for this period worsens outcomes in patients without progressive neurologic findings. Spontaneous improvement in MRI-documented cervical disk pathology has been demonstrated with a high rate of resolution. Surgery increases the likelihood that patients will have to have future procedures with higher complication rates. A 12% reoperation rate was reported in one large series. Patients with comorbid conditions, such as cardiac or respiratory disease, diabetes, or mental illness, may be poor candidates for surgery. Comorbidity can be judged and discussed carefully with the patient... patients with radiation of pain to the arm(s) and hand(s) had better relief of pain with surgery than those with neck pain alone. Pre-surgical screening should include consideration of psychological evaluation." Additionally, in support of MTUS/ACOEM, ODG states "Fusion, anterior cervical recommended as an option in combination with anterior cervical discectomy for approved indications, although current evidence is conflicting about the benefit of fusion in general." The records do not include a psychological evaluation as recommended by MTUS/ACOEM and do not include imaging studies to objectively document pathology to the cervical spine as recommended by MTUS/ACOEM. Therefore, this request for Anterior Cervical Discectomy with Interbody Fusion is not medically necessary at this time and is non-certified.

Inpatient Stay x 2 days: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) neck chapter, hospital length of stay.

Decision rationale: Surgical intervention is not medically necessary at this time. ODG states "Cervical Fusion, Anterior (81.02 -- Other cervical fusion, anterior technique); Actual data -- median 1 day; mean 2.2 days (Â±0.1); discharges 161,761; charges (mean) $50,653; Best practice target (no complications) -- 1 days." As the surgical intervention is not medically necessary, there would be no need for a length of stay. This request for Inpatient Stay X2DAYS is non-certified.