

Case Number:	CM14-0003728		
Date Assigned:	02/03/2014	Date of Injury:	05/07/2010
Decision Date:	06/20/2014	UR Denial Date:	12/25/2013
Priority:	Standard	Application Received:	01/10/2014

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 has a subspecialty 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 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 50-year-old female who reported injury on 05/07/2010. The mechanism of injury was the injured worker was reaching above her head to pull a box of equipment down when the entire stock began to fall towards the injured worker and around the injured worker. The injured worker reached up to grab the boxes to stop them and catch them. The injured worker underwent an MRI of the cervical spine on 09/06/2013 which revealed at C3-4 there was an annular concentric broad-based 2.8 mm disc protrusion seen flattening and abutting the anterior portion of the thecal sac with mild bilateral neural foraminal stenosis. There was no extrusion or sequestration of the disc material. At the level of C4-5, there was an annular concentric broad-based 3.0 mm disc protrusion seen flattening and abutting the anterior portion of thecal sac with mild bilateral neural foraminal stenosis. There was no extrusion or sequestration of the disc material. At the level of C5-6, there was an annular concentric left greater than right paracentral 3.8 mm disc protrusion flattening and abutting the anterior left greater than right portion of the thecal sac with left greater than right lateral spinal and mild to moderate left and mild right neural foraminal stenosis. There was no extrusion or sequestration of the disc material. At the level of C6-7, there was an annular concentric and broad-based 3.2 mm disc protrusion flattening and abutting the anterior portion of the thecal sac with bilateral lateral spinal and neural foraminal stenosis. There was no cord compression or cord edema. There was no extrusion or sequestration of the disc material. At the level of C7-T1, there was no posterior disc protrusion, compromise of the sac, cord or neural foramina and no significant compromise of the neural foraminal exit zones. The facet joints were unremarkable. The documentation of 10/01/2013 was the procedure note. The indications were the injured worker failed to achieve satisfactory improvement after rest, medications and physical therapy. The injured worker continues to have cervical pain and wished to proceed with cervical epidural

steroid injections. The diagnoses are cervical radiculopathy, displacement of cervical intervertebral disc, cervical spinal stenosis, cervical degenerative disc disease and myalgia.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETROSPECTIVE 10 THERAPEUTIC PERCUTANEOUS EPIDURAL DECOMPRESSION NEUROPLASTY OF THE CERVICAL NERVE ROOTS FOR ANALGESIA BILATERALLY AT C2, C3, C4, C5, C6, C7 ANCS ON CERVICAL SPINE AND CORD INCLUDING USE OF SEDATION: 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, Adhesiolysis, percutaneous, do not address sedation - Deer, T. R., Mekhail, N., Lopez, G., & Amirdelfan, K. (2011). Minimally invasive lumbar decompression for spinal stenosis. *Journal of Neurosurgical Review*, 1(S1).

Decision rationale: The Official Disability Guidelines indicate that percutaneous adhesiolysis is not recommended due to the lack of sufficient literature supporting the procedure. It further indicates that this procedure is also referred to as an epidural neurolysis or epidural neuroplasty or lysis of epidural adhesions. The clinical documentation submitted for review failed to provide documentation of exceptional factors to warrant nonadherence to guideline recommendations. Per Deer, T. R., et. al. (2011) "Conscious sedation for spine procedures in the ambulatory setting is associated with a low rate of adverse events comparable to local anesthesia without conscious sedation". Sedation would be appropriated, if the procedure was approved. The procedure was found not to be medically necessary. Given the above, the request for retrospective 10 therapeutic percutaneous epidural decompression neuroplasty of the cervical nerve roots for analgesia bilaterally at C2, C3, C4, C5, C6 and C7 ANCS on cervical spine and cord including the use of sedation is not medically necessary.