MAXIMUS Federal Services

Case Number:	CM14-0150038		
Date Assigned:	09/18/2014	Date of Injury:	12/01/2011
Decision Date:	10/29/2014	UR Denial Date:	09/04/2014
Priority:	Standard	Application Received:	09/15/2014

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 57-year-old female who reported an injury on 12/01/2011. Reportedly while working at [redacted] restaurant as an assistant manager, the injured worker stepped on the floor and accidently fell to the ground, landing on both outstretched arms and knees. She sustained injuries to her neck, right shoulder, and bilateral knees. The injured worker's treatment history included MRI studies of the knees, medications, physical therapy, surgery, EMG/NCV studies, and a back brace. The injured worker had undergone an EMG/NCV study that was done on 04/22/2014 that documented no evidence of cervical radiculopathy, mild right median nerve neuropathy. The injured worker had undergone MRI of the cervical spine on 02/26/2014 that revealed increased thyroid gland enlargement, most likely representing a goiter, has slightly increased. Moderate to severe C6-7 unchanged canal narrowing secondary to posterior disc osteophyte complex in conjunction with retrolisthesis of C6 on C7. Unchanged moderate C5-6 canal narrowing. Severe right C3-4 moderate to severe right C4-5 severe right C5-6 and severe left C6-7 foraminal narrowing. The injured worker was evaluated on 08/13/2014 and was documented the injured worker reported that her pain was increasing. In the last 3 months she noticed that she was dropping objects, clumsiness of the hands, and urinary tension symptoms. Radicular symptoms persist. Neurogenic bladder symptoms have been present for the last 6 months. She presented with neck pain. Location in the lower anterior cervical area. Symptoms were described as pins and needles, aching, and pressure. Symptoms were increasing. The symptom was alleviated by pain medication. The symptom was exacerbated by exertion. Radiating down the right arm. The injured worker's pain was 2/10 on the pain scale and reported pain severity was moderate. Physical examination of the cervical spine revealed no deformity, erythema, soft tissue swelling, ecchymosis, or atrophy; palpation moderate tenderness was present at the upper right paraspinal muscles and upper left paraspinal muscles; range of motion

was decreased throughout; specialized tests Spurling's test produced pain radiating down the right arm; the Lhermitte's test was negative; the Hoffmann's sign of pyramidal tract disease was positive on the right. Neurological sensation was decreased on the right in the C6 dermatome and decreased on the left in the C5 dermatome; deep tendon reflexes left triceps reflex was 2+; right triceps reflex 2+; left/right brachioradialis reflex was 2+. The injured worker was unable to perform heel/toe walk. The diagnoses included cervical spondylosis with myopathy, cervical degenerative disc disease, cervical stenosis, cervicalgia, cervical radiculopathy, and C4-5 spondy present, DDD, NFS right side, C5-6 disc bulge, central stenosis, DDD A/P: 7.5 mm, right NFS, C6-7 disc bulge, central stenosis, DDD A/P: 6.0 mm, left NFS. The request for authorization dated 08/25/2014 was for an anterior cervical discectomy and fusion C4 to C7, inpatient, and cardiac clearance.

IMR ISSUES, DECISIONS AND RATIONALES

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

Anterior Cervical Discectomy and fusion C4 to C7, inpatient: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Indications for Surgery, Discectomy, Laminectomy cervical spine

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 181-183. Decision based on Non-MTUS Citation Neck and Upper Back. Fusion, Anterior Cervical. Discectomy-laminectomy-laminoplasty.

Decision rationale: The request for C4-5, C6-7 anterior cervical discectomy fusion with instrumentation is not medically necessary. According to the California MTUS/ACOEM do not recommend discectomy or fusion without conservative treatment 4 to 6 weeks minimum. Discectomy or fusion for no radiating pain or in absence of evidence of nerve root compromise. Furthermore, the Official Disability Guidelines (ODG) recommends as an option in combination with anterior cervical discectomy for approved indications, although current evidence is conflicting about the benefit of fusion in general. Evidence is also conflicting as to whether auto graft or allograft is preferable and/or what specific benefits are provided with fixation devices. Many patients have been found to have excellent outcomes while undergoing simple discectomy alone (for one- to two-level procedures), and have also been found to go on to develop spontaneous fusion after an anterior discectomy. Cervical fusion for degenerative disease resulting in axial neck pain and no radiculopathy remains controversial and conservative therapy remains the choice if there is no evidence of instability. Conservative anterior cervical fusion techniques appear to be equally effective compared to techniques using allografts, plates or cages. Cervical fusion may demonstrate good results in appropriately chosen patients with cervical spondylosis and axial neck pain. One meta-analysis found the differences in benefits and harms between the various surgical techniques are small. The surgeon, patient, and health care provider can therefore make the choice of any surgical technique based on experience, preferences, or costs. According to another systematic review, evidence suggests that surgery with or without fusion can be similarly effective, so surgeons should consider each case individually and take into account their own familiarity and expertise with each procedure. This

evidence was substantiated in a recent Cochrane review that stated that hard evidence for the need for a fusion procedure after discectomy was lacking, as outlined below: (1) Anterior cervical discectomy compared to anterior cervical discectomy with interbody fusion with a bone graft or substitute: Three of the six randomized controlled studies discussed in the 2004 Cochrane review found no difference between the two techniques and/or that fusion was not necessary. The Cochrane review felt there was conflicting evidence of the relative effectiveness of either procedure. Overall it was noted that patients with discectomy only had shorter hospital stays, and shorter length of operation. There was moderate evidence that pain relief after five to six weeks was higher for the patients who had discectomy with fusion. Return to work was higher early on (five weeks) in the patients with discectomy with fusion, but there was no significant difference at ten weeks. One disadvantage of fusion appears to be abnormal kinematic strain on adjacent spinal levels. The guidelines recommends discectomy as an option if there is a radiographically demonstrated abnormality to support clinical findings consistent with one of the following: (1) Progression of myelopathy or focal motor deficit; (2) Intractable radicular pain in the presence of documented clinical and radiographic findings; or (3) Presence of spinal instability when performed in conjunction with stabilization. Surgery is not recommended for disc herniation in a patient with non-specific symptoms and no physical signs. In addition, although surgery for spondylosis and radiculopathy may offer some short term benefit, non-operative treatment with PT can provide similar improvement in pain and function at 12-16 months for patients without progressive neurologic deficits or instability. The American Academy of Orthopedic Surgeons has recommended that an anterior approach is appropriate when there is evidence of radiculopathy, and/or when there is evidence of central location and there is any degree of segmental kyphosis. A posterior approach has been suggested by the same group when there is evidence of lateral soft disc herniation's with predominate arm pain and for caudal lesions in large, short-necked individuals. Guidelines state for anterior cervical discectomy and fusion C4 to C7, the recommendation require presence of all of the following criteria prior to surgery for each nerve root that has been planned for intervention. There must be evidence of radicular pain, sensory symptoms in a cervical distribution that correlates with involved cervical level or presence of positive Spurling's test. There must be evidence that the injured worker has received or failed at least 6 to 8 weeks of trial of conservative care which has not been documented. As such, the request for anterior cervical discectomy and fusion C4 to C7, inpatient is not medically necessary.

Cardiac clearance: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Indications for Surgery, Discectomy, Laminectomy cervical spine

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Low Back & Lumbar & Thoracic (Acute & Chronic) Preoperative Testing, General

Decision rationale: The request for preoperative EKG not medically necessary. Per the Official Disability Guidelines (ODG) recommends. Preoperative testing (e.g., chest radiography, electrocardiography, laboratory testing, and urinalysis) is often performed before surgical procedures. These investigations can be helpful to stratify risk, direct anesthetic choices, and guide postoperative management, but often are obtained because of protocol rather than medical necessity. The decision to order preoperative tests should be guided by the patient's clinical history, comorbidities, and physical examination findings. Patients with signs or symptoms of active cardiovascular disease should be evaluated with appropriate testing, regardless of their

preoperative status. Electrocardiography is recommended for patients undergoing high-risk surgery and those undergoing intermediate-risk surgery who have additional risk factors. Patients undergoing low-risk surgery do not require electrocardiography. Chest radiography is reasonable for patients at risk of postoperative pulmonary complications if the results would change perioperative management. Patients in their usual state of health who are undergoing cataract surgery do not require preoperative testing. Routine preoperative tests are defined as those done in the absence of any specific clinical indication or purpose and typically include a panel of blood tests, urine tests, chest radiography, and an electrocardiogram (ECG). These tests are performed to find latent abnormalities, such as anemia or silent heart disease that could impact how, when, or whether the planned surgical procedure and concomitant anesthesia are performed. It is unclear whether the benefits accrued from responses to true-positive tests outweigh the harms of false-positive preoperative tests and, if there is a net benefit, how this benefit compares to the resource utilization required for testing. 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. Based on decision 1, request for anterior cervical discectomy and fusion C4 to C7, inpatient, is not medically necessary, the request for cardiac clearance is not medically necessary.