

<b>Case Number:</b>	CM14-0174171		
<b>Date Assigned:</b>	10/24/2014	<b>Date of Injury:</b>	09/17/2013
<b>Decision Date:</b>	12/03/2014	<b>UR Denial Date:</b>	10/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/20/2014

### 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 51-year-old male who reported an injury on 09/17/2013 due to cumulative trauma. On 05/16/2014, the injured worker presented with neck pain, bilateral shoulder blade pain, left low back and buttock pain, and left groin and knee pain associated with numbness of the right thumb and index finger. He noted that there was increased pain and weakness in the left side which had gradually worsened, and he reported that he could not function. Prior surgeries included a C3 to C7 posterior instrumentation, C3 to T2 revision fusion, and hemiarthroplasty of the bilateral knees. Upon examination of the cervical spine, there was tenderness in the trapezius muscles, supraspinatus muscles bilaterally, and paravertebral muscles and rhomboids. There were positive bilateral Spurling's tests and decreased sensation in the bilateral hands. There was intact sensation and 4/5 strength in the upper extremities. There was absent bilateral deep tendon reflexes in the C5 to C6, and positive bilateral Hoffman's tests noted. Other therapies included medications and surgeries. The provider recommended a cervical spine surgery, retrospective for date of service 11/20/2013 to include a decompressive laminectomy, left sided approach, DePuy laminoplasty system posterior fusion, local bone graft posterior segmental instrumentation, and anterior cervical discectomy. There was no rationale provided. The Request for Authorization Form was not included in the medical documents for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Cervical spine surgery completed 11/20/13 to include Decompressive Laminoplasty C3-C7, Left Sided Approach, DePuy Laminoplasty System Posterior Fusion, C2-T2 with BMP In-Fuse, Graft-On Matrix Allograft, Local Bone Graft Posterior Segmental Instrumentation C2-T2, DePuy Mountainer 3.5/5.5 Expedium Sys: 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 12 Low Back Complaints Page(s): 179-181. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back, Discectomy-laminectomy-laminoplasty, and Fusion, posterior cervical

**Decision rationale:** The request for Cervical spine surgery completed 11/20/13 to include decompressive laminoplasty C3-C7, left sided approach, depuy laminoplasty system posterior fusion, C2-T2 with BMP in-fuse, graft-on matrix allograft, local bone graft posterior segmental instrumentation C2-T2, depuy mountainer 3.5/5.5 expedium system and anterior cervical discectomy C5-6, C6-7, and C7-T1 with Depuy VG-2 allografts is not medically necessary. The California MTUS/ACOEM Guidelines state that fusion for nonradiating pain is not recommended in the absence of evidence of root compromise. The first 3 months of onset, surgical consideration is recommended following severe spinal pathology and severe debilitating symptoms with neurologic evidence of specific nerve root or spinal cord dysfunction corroborated on appropriate imaging studies that did not respond to conservative therapy. The Official Disability Guidelines further state that discectomy and laminoplasty are recommended as an option if there is radiographically demonstrated abnormality to support clinical findings consistent with progression in myelopathy or focal motor deficit, intractable radicular pain in the presence of documented clinical and radiographic findings, presence of spine with instability, and is not recommended for disc herniation. According to the Official Disability Guidelines, a fusion is indicated for Spinal Injury, osteomyelitis, metastatic bone tumor, cervical root compression, spondylotic myelopathy and increased significant function limitation resulting in inability to or a significantly decreased ability to perform normal daily activities. Posterior cervical fusion is under study. A fusion and stabilization procedure is often used to treat cervical instability secondary to a traumatic injury, rheumatoid arthritis, ankylosing spondylosis, neoplastic disease, infections, and previous laminectomy. The guidelines state that a posterior cervical fusion is under study and there is no evidence of cervical instability secondary to a traumatic injury, rheumatoid arthritis, or neoplastic disease and infections. There is a lack of documentation regarding the failure of conservative measures prior to the surgery. No clinical notes were submitted from prior to the surgery. No official imaging studies were provided. As such, medical necessity has not been established; therefore this request is not medically necessary.

**Lumbar Surgery completed 7/16/14 to include McCullough Decompression, Inferir L2-Superior L5, Left Approach: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints  
Page(s): 306.

**Decision rationale:** The request for lumbar surgery completed 7/16/14 to include McCullough decompression, inferior L2-superior L5, left approach is not medically necessary. The California MTUS/ACOEM Guidelines state that direct methods of nerve root decompression include inferior laminotomy, standard discectomy, and laminectomy is carefully selected for injured workers with nerve root compression due to lumbar disc prolapse and provides faster relief from acute and conservative management. Positive and negative effects of the lifetime natural history of the underlying disc disease are unclear. There is a lack of evidence of lumbar nerve root compression with imaging studies to support surgical intervention. Additionally there is a lack of documentation of conservative treatments that were tried and failed, or the efficacy of prior treatments provided. As such, medical necessity has not been established; therefore this request is not medically necessary.