

Case Number:	CM14-0179053		
Date Assigned:	11/03/2014	Date of Injury:	11/28/2008
Decision Date:	12/12/2014	UR Denial Date:	10/14/2014
Priority:	Standard	Application Received:	10/28/2014

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 Surgeon, 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 55-year-old female who reported injury on 11/28/2008. The mechanism of injury was not provided. The injured worker underwent a left shoulder arthroscopy, acromioplasty, and a distal clavicle resection/Mumford procedure on 05/28/2010. The injured worker underwent an anterior discectomy and fusion at C5-6 on 01/13/2012. The injured worker was noted to undergo a cervical discogram on 07/25/2013, which revealed disconcordant pain reproduction at C3-4 and C4-5 and partial to full concordancy at C6-7. There was normal morphology of the discs. Other therapies included medication and a rhizotomy. The injured worker's medications were noted to include Ultram ER 150 mg 1 tablet daily, synovacin 500 mg 1 tablet 3 times a day, Prilosec 20 mg daily, Ambien 10 mg at bedtime, Prozac 10 mg daily, Imitrex 100 mg 1 tablet daily, Medi Flex 3 times a day, and Norco 10/325 mg 1 tablet twice a day. The documentation indicated the injured worker had EMG/NCV studies of the upper extremities on 05/05/2011, which revealed an acute left C6 radiculopathy. The injured worker was noted to undergo an MRI of the cervical spine on 07/07/2009, which revealed a C5-6 and a midline and right paracentral disc protrusion effacing the spinal cord combined with bilateral uncovertebral and facet arthropathy resulting in mild bilateral encroachment on the neuroforaminal and exiting nerve roots. There was uncovertebral facet joint arthrosis that was moderate bilaterally, as well as moderate bilateral facet joint arthrosis at C6-7. There was moderate decrease of cervical spine lordosis. The MRI of 04/20/2011 revealed at the level of C6-7 there was a minimal 1 mm disc protrusion without compromise of the spinal canal or neural foramina. At C5-6, there was a 3 mm disc protrusion abutting the thecal sac. There was a right greater than left neuro foraminal narrowing. There was facet and uncinat arthropathy noted. The documentation of 12/11/2013 revealed the injured worker underwent x-rays of the lumbosacral spine, 5 views showing a slight loss of disc space height at L4-5. There were

minimal degenerative changes noted. There was no evidence of spondylolisthesis or spondylosis. Most significantly, there was evidence of facet arthropathy at L4-5 and L5-S1. The flexion and extension x-rays revealed no translation or angular instability. MRI of 04/20/2011 revealed at the level of C6-7 there was a minimal 1 mm disc protrusion without compromise of the spinal canal or neural foramina. At C5-6, there was a 3 mm disc protrusion abutting the thecal sac. There was a right greater than left neuro foraminal narrowing. There was facet and unciniate arthropathy noted. The documentation of 09/24/2014 revealed the injured worker wanted to proceed with a revision surgery discussed in 09/2013. Documentation indicated the injured worker had been evaluated by an agreed medical evaluator who agreed with the request from 09/18/2013 of a cervical revision and fusion extending to C6-7. The injured worker had increased numbness throughout her upper extremities. The documentation indicated the injured worker had failed all attempts of conservative in home treatment, as well as therapeutic injections. The physical examination revealed the injured worker had constant moderate pain of the cervical spine intermittently increased to moderately severe or severe based upon activity levels. The injured worker had numbness, tingling, and paresthesias extending down the left upper extremity and to her hand. The injured worker had generalized weakness of the left upper extremity. There was spinal process tenderness at C6-7. There was moderate paraspinal muscle guarding with tenderness. There was moderate occipital tenderness and moderate trapezius spasm with tenderness. The injured worker had greater tenderness on the left than the right. The injured worker had decreased range of motion. The injured worker had vague hypesthesia of the entire left hand and thumb and fingers compared with the right side slightly more hypoesthetic ulnarly than radially. There was weakness of grip of the left hand, weakness of left biceps, triceps, and shoulder abduction compared to the opposite side. The deep tendon reflexes were 1+ bilaterally. The diagnoses included status post anterior cervical fusion and discectomy with retained anterior cervical plate at C5-6 and cervical spondylosis at C3-4, C4-5, and C6-7, primarily symptomatic at C6-7. The discussion included the injured worker had undergone physical therapy, home exercise, home modalities, TENS unit, acupuncture, and therapeutic injections, and as such, surgical intervention would be appropriate. The request was made for a removal of the retained anterior cervical plate at C5-6 with anterior cervical fusion and discectomy at C6-7 with right iliac aspiration, bone graft and cervical plate, and a 1 to 2 day hospital stay with surgical clearance. There was no Request for Authorization submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Removal of retained anterior cervical plate at C5-6: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 180. Decision based on Non-MTUS Citation Official Disability Guidelines

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, Hardware implant removal (fixation)

Decision rationale: The Official Disability Guidelines indicate that hardware implant removal is not recommended except in the case of broken hardware or persistent pain and is recommended after ruling out other causes of pain such as infection and nonunion. The clinical documentation submitted for review failed to indicate the injured worker had broken hardware. There was a lack of documentation indicating that other causes of pain had been ruled out, including infection and nonunion. There was a lack of documentation of radiologic findings to support the necessity for intervention. Given the above, the request for removal of retained anterior cervical plate at C5-6 is not medically necessary.

Anterior cervical fusion and discectomy at C6-7 with iliac aspiration, bone graft and cervical plate: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 180. Decision based on Non-MTUS Citation Official Disability Guidelines

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

Decision rationale: The American College of Occupational and Environmental Medicine indicates that a surgical consultation may be appropriate for patients who have activity limitation for more than 1 month or with extreme progression of symptoms. There should be documentation of clear clinical, imaging, and electrophysiological evidence consistently indicating the same lesion that has been shown to benefit from surgical repair in both the short and long term. There should be documentation of unresolved radicular symptoms after receiving conservative treatment. The efficacy of cervical fusion for patients with chronic cervical pain without instability has not been demonstrated. The clinical documentation submitted for review indicated the injured worker had failed conservative care. There was documentation of clinical findings. However, the imaging findings did not support the necessity for surgical intervention. The electrophysiologic evidence indicated the injured worker had findings on the left at C6. Given the above, the request for anterior cervical fusion and discectomy at C6-7 with iliac aspiration, bone graft and cervical plate is not medically necessary.

Associated surgical service: Inpatient hospital stay x 1-2 days: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: As the requested surgical intervention is not supported by the documentation, the requested ancillary service is also not supported.

Associated surgical service: Surgery 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: As the requested surgical intervention is not supported by the documentation, the requested ancillary service is also not supported.