Case Number:	CM14-0040963		
Date Assigned:	06/30/2014	**Date of Injury:**	04/16/2012
Decision Date:	09/18/2014	**UR Denial Date:**	03/25/2014
Priority:	Standard	**Application Received:**	04/08/2014

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 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 claimant is a 54 year old who injured the neck and right knee in a work related accident on 4/16/09. Records provided for review specific to the claimant's neck include the report of a 6/15/13 MRI identifying at the C4-5 level disc desiccation and posterior disc bulging with no neural foraminal compromise. The C5-6 level also showed disc desiccation, encroachment of the neural foramina with mild disc bulging, and a disc osteophyte complex. At the C6-7 level there was a dehydrated disc, a disc osteophyte complex and encroachment on the exiting neural foramina bilaterally. The report of clinical reassessment on 2/13/14 noted continued neck and headache complaints. Physical examination showed cervical tenderness, pain with axial loading and diminished sensation in a C5-7 dermatomal distribution. Based on failed conservative care, the recommendation was made for a three level anterior cervical discectomy and fusion with implementation of hardware.

IMR ISSUES, DECISIONS AND RATIONALES

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

C4-C7 Anterior cervical discectomy with implantation of hardware: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEMOfficial Disability Guidelines(ODG) - Treatment in Workers' Compensation (TWC).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 180. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Worker's Comp, 18th Edition, 2013: neck procedure -Fusion, anterior cervicalRecommended as an option in combination with anterior cervical discectomy for approved indications, although current evidence is conflicting about the benefit of fusion in general. (See Discectomy/laminectomy/laminoplasty.) Evidence is also conflicting as to whether autograft 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. (Bertalanffy, 1988) (Savolainen, 1998) (Donaldson, 2002) (Rosenorn, 1983) 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. (Bambakidis, 2005) Conservative anterior cervical fusion techniques appear to be equally effective compared to techniques using allografts, plates or cages. (Savolainen, 1998) (Dowd, 1999) (Colorado, 2001) (Fouyas-Cochrane, 2002) (Goffin, 2003) Cervical fusion may demonstrate good results in appropriately chosen patients with cervical spondylosis and axial neck pain. (Wieser, 2007) 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. (Jacobs-Cochrane, 2004) (Abd-Alrahman, 1999) (Dowd, 1999) (Martins, 1976) (van den Bent, 1996) (Savolainen, 1998) One disadvantage of fusion appears to be abnormal kinematic strain on adjacent spinal levels. (Ragab, 2006) (Eck, 2002) (Matsunaga, 1999) (Katsuura, 2001) The advantage of fusion appears to be a decreased rate of kyphosis in the operated segments. (Yamamoto, 1991) (Abd-Alrahman, 1999)(2) Fusion with autograft versus allograft: The Cochrane review found limited evidence that the use of autograft provided better pain reduction than animal allograft. It also found that there was no difference.

Decision rationale: Based on the California ACOEM Guidelines and supported by the Official Disability Guidelines, the request for C4-C7 Anterior cervical discectomy with implantation of hardware cannot be recommended as medically necessary. The medical records do not document any clinical assessment, physical examination or imaging that correlates findings at three levels to support the requested operative procedure. There is currently no indication of compressive pathology at C4-5 or C5-6 available for review. ACOEM Guidelines indicate correlation between physical examination findings and imaging to support the need of operative process. Three level surgical request with hardware would not be indicated. As such, the request is not medically necessary.

2-3 days inpatient stay: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) - Treatment in Workers' Compensation (TWC).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Worker's Comp, 18th Edition, 2013: neck procedure -Fusion, anterior cervical: Hospital length of stay (LOS).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) $50,653Best practice target (no complications) -- 1 days.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

DME Pruchase: cervical collar: Minerva Mini collar #1: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEMOfficial Disability Guidelines (ODG) - Treatment in Workers' Compensation (TWC).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173-175.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.