

Case Number:	CM14-0064317		
Date Assigned:	07/23/2014	Date of Injury:	03/21/2011
Decision Date:	08/27/2014	UR Denial Date:	04/29/2014
Priority:	Standard	Application Received:	05/07/2014

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 Internal Medicine 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 58 year old male who was injured in a motor vehicle accident while working as a bus driver for a school district. Available records were reviewed with a brief and pertinent summary to follow. At the latest evaluation in March 2014, the injured worker was recommended to have cervical anterior discectomy with fusion by his neurosurgeon after a second opinion with a spine surgery certified orthopedic surgeon. The injured worker has severe neck pain, a sensation of popping and shoulder pain that is burning in quality, made worse with neck rotation and motion during driving. Motor and reflex function was normal on examination in 2013 but radiculopathic pain is suggested by the burning severe pain. The MRI done in December 2013 confirmed the presence of a herniated broad based disc at the C6-C7 level with bilateral neuroforaminal narrowing and impingement of the thecal sac with indentation of the spinal cord itself. No spinal cord signal abnormality was noted on the MRI. The patient has had conservative treatment as documented by various physicians although specific details are unavailable other than an epidural steroid injection. At multiple points in the medical record, physicians have documented that the patient is exhausted of conservative options.

IMR ISSUES, DECISIONS AND RATIONALES

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

C6-7 Anterior cervical fusion, with instrumentation QTY: 1:00: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. 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 American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Cervical and Thoracic Spine Disorders, Section on Surgical Considerations (electronically cited) Other Medical Treatment Guideline or Medical Evidence: Carragee EJ, Hurwitz EL, Cheng I, Carroll LJ, Nordin M, Guzman J, et al. Treatment of neck pain: injections and surgical interventions: results of the Bone and Joint Decade 2000-2010 Task Force on Neck Pain and Its Associated Disorders. Spine. 2008; 33(4 Suppl): S153-S169.

Decision rationale: The aforementioned referenced guidelines state the following regarding surgical considerations in cervical spine disorders. Within the first three months after onset of acute neck or thoracic spine symptoms, surgery is considered for serious spinal pathology, nerve root compression not responsive to an adequate trial of conservative therapy generally considered to require at least six weeks, or the development of a documented, progressive neurological deficit. The injured worker has evidence of symptoms of radiculopathy, in particular radiculopathic pain made worse by turning of the head to the affected side along with imaging evidence of neuroforaminal stenosis, degenerative disk disease at C6 and C7 with loss of height of approximately 80% along with a protrusion of the disc that is broad based. This is despite an epidural steroid injection and several months of evaluation records confirming that the patient has had symptoms for a long time with ongoing severe progressive symptoms. As such, the patient's clinical condition warrants surgical treatment for early and reliable relief of symptoms early in the post operative period although long term outcomes are not available and whether fusion is necessary in the absence of spinal instability is controversial. Nonetheless, many neurosurgical experts recommend fusion because of the potential to reduce long term instability. Anterior discectomy has been reliably shown to reduce short term morbidity as available in the second reference mentioned above. As such, the C6-7 Anterior cervical fusion, with instrumentation is medically necessary.

Pre-operative labs, Chest x-ray, EKG: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines/ Integrated Treatment/Disability Duration Guidelines Neck and Upper Back Chapter (updated 04/14/14).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Section - Low back, Lumbar and Thoracic; Subsection - Preoperative lab testing, Preoperative electrocardiogram.

Decision rationale: Pre operative labs, chest x ray and EKG are not necessary in patients with no risk factors and undergoing low or intermediate risk surgery and without clinical signs and symptoms of kidney, liver, lung or heart disease. The patient is indicated to have no underlying medical conditions and has no symptoms or signs of any organ dysfunction documented. As noted in ACOEM, diagnostic testing should only be done when there is clinical suspicion of a condition and a specific question is formulated. The plans to deal with possible results of

diagnostic testing should be enumerated and decided prior to testing. Otherwise testing is generally not recommended. As such, the request for pre operative labs, chest x-ray and EKG are not medically necessary.