

Case Number:	CM13-0070756		
Date Assigned:	01/29/2014	Date of Injury:	03/29/1999
Decision Date:	05/06/2015	UR Denial Date:	12/11/2013
Priority:	Standard	Application Received:	12/26/2013

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: Illinois, California, Texas
 Certification(s)/Specialty: Orthopedic Surgery

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 56-year-old male with a date of injury of 3/29/99, relative to a slip and fall. He underwent a C5/6 discectomy and fusion in January 2001, and a subsequent C6/7 discectomy and fusion using the LDR cage and allograft bone on 10/12/12. Past surgical history was positive for anterior and posterior lumbar fusion at L4/5 and L5/S1 in 2004. The 6/3/13 cervical x-rays conclusion documented status post C6/7 fusion without significant change or acute abnormality, and C3/4 and C4/5 mild degenerative disc disease. The 8/9/13 CT scan impression documented prior anterior cervical discectomy and fusion at C5/6 with minimal bilateral foraminal stenosis, and prior anterior cervical discectomy and fusion at C6/7 with moderately severe right and mild left foraminal stenosis. Findings indicated that the hardware at C6/7 appeared intact and engaged with no abnormal motion on flexion/extension views. The 11/13/13 treating physician report cited significant neck discomfort and interscapular pain. Upper extremity numbness had resolved post-operatively. He also developed some lower back pain on the right side after he twisted his low back approximately one month ago. Physical exam documented significantly diminished range of motion in lateral flexion, mild limitation in flexion and extension, and mild to moderate pain upon palpation and with movement. Bilateral upper and lower extremity strength was normal. Lumbar spine exam documented diminished range of motion with pain in flexion/extension, right lumbar tenderness to palpation, and ambulation with discomfort. The CT scan 2½ months ago demonstrated good placement of the C6/7 LDR cage with bone graft in the cage but solid fusion could not be determined. There was moderate right and mild left C7 foraminal stenosis with facet arthropathy. There was solid fusion at C5/6. The

assessment was status post C6/7 anterior cervical discectomy and fusion with LDR cage and allograft bone with persistent neck pain and previous C5/6 fusion, and possible C6/7 pseudoarthrosis. The treatment plan recommended posterior C6/7 foraminotomies and fusion with fixation to address persistent neck and interscapular pain most likely due to pseudoarthrosis at C6/7. The injured worker would like to try physical therapy for the cervical spine and this was ordered. The 11/18/13 cervical spine x-rays showed cervical fusion C5 through C7, unchanged from 6/3/13. There were minor degenerative changes elsewhere that were stable. There was no evidence of flexion/extension instability. The 12/11/13 utilization review non-certified the requests for posterior laminectomy and fusion C6/7 with associated inpatient stay and post-op physical therapy. The rationale for non-certification indicated that there was no imaging evidence of pseudoarthrosis to support an additional cervical fusion procedure.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy (6-visits for the lumbar spine): Overturned

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 9, 98-99.

Decision rationale: The California MTUS guidelines recommend therapies focused on the goal of functional restoration rather than merely the elimination of pain. In general, the MTUS guidelines would support up to 9 to 10 visits for myalgia/myositis. Guideline criteria have been met. This patient presents with a flare of low back pain with functional difficulty in ambulation. A trial of six physical therapy visits to reduce pain and restore function is consistent with guidelines. Therefore, this request is medically necessary.

Posterior Laminectomy and Fusion at C6-C7 with Autograft and Instrumentation: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 179-181. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back Chapter, Discectomy-Laminectomy-Laminoplasty; Fusion, Posterior Cervical.

Decision rationale: The California Medical Treatment Utilization Schedule guidelines provide a general recommendation for cervical decompression and fusion surgery, including consideration of pre-surgical psychological screening. The Official Disability Guidelines (ODG) provides specific criteria for cervical laminectomy. Surgical indications include evidence of radicular pain and sensory symptoms in a cervical distribution that correlate with the involved cervical level or a positive Spurling's test, evidence of motor deficit or reflex changes or positive EMG findings

that correlate with the involved cervical level, abnormal imaging correlated with clinical findings, and evidence that the patient has received and failed at least a 6-8 week trial of conservative care. Guidelines state that posterior cervical fusion is under study. A posterior fusion and stabilization procedure is often used to treat cervical instability secondary to traumatic injury, rheumatoid arthritis, ankylosing spondylitis, neoplastic disease, infections, and previous laminectomy, and in cases where there has been insufficient anterior stabilization. Guideline criteria have not been met. The injured worker presented with persistent neck and interscapular pain following C6/7 anterior cervical discectomy and fusion. He was status post remote ACDF at C5/6. X-rays and CT scan findings documented cervical fusion from C5 to C7 with no evidence of failure of fusion or hardware, and no instability on flexion/extension. The treating physician opined that persistent pain was due to pseudoarthrosis as fusion was not clearly evident on the CT scan. There was no clinical evidence of reflex or motor changes. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. Given the lack of clear imaging evidence of pseudoarthrosis and no indication that conservative treatment had been tried and failed, this request is not medically necessary.

Inpatient Hospital Stay (3-Days): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back Chapter, Hospital Length of Stay (LOS).

Decision rationale: As the surgical request is not supported, this request is not medically necessary.