

Case Number:	CM15-0101784		
Date Assigned:	06/04/2015	Date of Injury:	04/25/2012
Decision Date:	07/02/2015	UR Denial Date:	05/26/2015
Priority:	Standard	Application Received:	05/27/2015

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:

This injured worker is a 6-year-old female who sustained an industrial injury on 4/25/12. Injury was reported after moving a patient from a gurney to a table while working as an RN in interventional radiology. Records documented recent conservative treatment to include prednisone taper, over-the-counter anti-inflammatory and analgesic medications, epidural steroid injections, and activity modification. The 4/7/15 and 4/28/15 treating physician reports did not document a physical exam. The 5/1/15 cervical spine MRI impression documented degenerative changes of the cervical spine with uncovertebral/facet hypertrophy and disc osteophyte complex resulting in foraminal and central canal narrowing, worst at C5/6. At C5/6, there was uncovertebral and facet hypertrophy with a left paracentral disc osteophyte complex resulting in moderate to severe left and moderate right neuroforaminal stenosis along with mild to moderate central canal narrowing. At C6/7, there was mild broad-based bulge and disc osteophyte complex with uncovertebral and facet hypertrophy resulting in mild to moderate bilateral neuroforaminal narrowing and mild central canal narrowing. At C7/T1, there was uncovertebral and disc osteophyte complex on the right resulting in mild to moderate right neuroforaminal narrowing. The 5/1/15 cervical spine x-ray findings documented multilevel degenerative changes. Osteophytes were present, predominantly anteriorly, most notably at the C4/5 level, but also diffusely from C4 through T1. There was multilevel disc height loss, predominantly at the C6/7 and C7/T1 levels. There was mild facet arthropathy predominantly at C7/T1. The 5/7/15 spine surgery report indicated the injured worker had a repeat flare-up of right C8 radiculopathy with pain, numbness and mild right hand weakness. She also had pain into the

right medial scapula, triceps, and mild triceps weakness. There was right ring and small finger numbness. MRI findings were reviewed. She had right mostly C8 radiculopathy, and was offered surgery at C7/T1. The 5/12/15 treating physician report indicated that the injured worker had a flare-up in early April with prior excellent improvement with cervical epidural steroid injection on 6/18/12 and 12/5/14. She underwent a C7/T1 interlaminar epidural steroid injection on 4/8/15 with initial excellent improvement but return of symptoms over 2 days. She attempted to return to work but was much worse. She had a surgical consultation on 5/7/15 that recommended surgical correction. Cervical MRI findings from 5/20/12 were reviewed. Physical exam was not documented. The diagnosis was cervical radiculopathy. Authorization was requested for right C7 and T1 foraminotomy/posterior approach surgery with possible hospital stay times 1 night. The 5/26/15 utilization review non-certified the request for right C7 and T1 foraminotomy/posterior surgery and associated length of stay as there was no evidence of a positive Spurling's test or any objective evidence of radiculopathy emanating from the requested surgical procedure level.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cervical right C7 and T1 foraminotomy/posterior surgery with possible hospital stay x 1 night: Overturned

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: Discectomy-laminectomy-laminoplasty; Hospital length of stay (LOS).

Decision rationale: The California Medical Treatment Utilization Schedule guidelines provide a general recommendation for cervical decompression surgery, including consideration of pre-surgical psychological screening. The Official Disability Guidelines (ODG) provide specific criteria for cervical discectomy. 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. If there is no evidence of sensory, motor, reflex or EMG changes, confirmatory selective nerve root blocks may be substituted if these blocks correlate with the imaging study. The block should produce pain in the abnormal nerve root and provide at least 75% pain relief for the duration of the local anesthetic. The ODG state the recommended median and best practice target for a cervical decompression surgery is 1 day. Guideline criteria have been met. This injured worker presents with neck and right upper extremity symptoms reported as consistent with C8 radiculopathy. She was not able to successfully return to work. There was imaging evidence at C7/T1 of mild to moderate right neuroforaminal narrowing but no evidence of nerve root compromise. There was no specific documentation of motor or sensory deficit or EMG findings. However, a C7/T1 epidural steroid injection was reported as providing excellent

relief for 2 days, followed by return of symptoms. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. Therefore, this request is medically necessary.