

Case Number:	CM15-0131166		
Date Assigned:	07/24/2015	Date of Injury:	08/29/2001
Decision Date:	09/01/2015	UR Denial Date:	06/12/2015
Priority:	Standard	Application Received:	07/07/2015

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 64-year-old male who sustained an industrial injury on 8/29/01. The mechanism of injury was not documented. Past surgical history was positive for bilateral L4/5 interlaminar decompression on 2/15/08. The 9/18/14 cervical spine MRI conclusion documented degenerative spondylotic changes in the cervical spine with reversal of the cervical curvature. There was grade 1 (2 mm) retrolisthesis of C4 on C5. There was facet joint arthrosis most prominent on the left at C3/4. At C3/4, there was left uncovertebral joint hypertrophy causing severe left neuroforaminal narrowing. At C4/5, there was a broad-based spur disc complex with bilateral uncovertebral joint hypertrophy effacing the anterior subarachnoid space with moderate central canal stenosis, and severe left and mild right neuroforaminal narrowing. At C5/6, there was a broad-based spur disc complex with bilateral uncovertebral joint hypertrophy partially effacing the anterior subarachnoid space with mild central canal stenosis, and severe right neuroforaminal narrowing. There was a broad-based spur disc complex with bilateral uncovertebral joint hypertrophy at C6/7 without central canal stenosis or cord compression, and severe left and mild right neuroforaminal narrowing. The 9/23/14 electrodiagnostic study evidence bilateral carpal tunnel syndrome with no evidence of a plexopathy or radiculopathy. The 4/30/15 treating physician report cited persistent numbness and tingling down his arms, and also symptoms of bilateral carpal tunnel syndrome with numbness and tingling of his hands at night. Physical exam documented weakness of the right abductor pollicis brevis and flattening, as compared to the left, consistent with atrophy. He was hyperreflexic consistent with his myelopathy and radiculopathy. He had clear-cut cervical radicular myelopathy secondary to C4

to C7 spinal stenosis and neuroforaminal encroachment. The treatment plan included right carpal tunnel release and C4-C7 anterior cervical discectomy and fusion with bone band and plate. He underwent right carpal tunnel release on 5/14/15. The 6/3/15 treating physician report indicated the patient had resolution of his right carpal tunnel symptoms following surgery. He still had numbness and tingling in his left hand. The treatment plan included left carpal tunnel release and C4 to C7 anterior cervical discectomy and fusion with bone band and plate. The 6/12/15 utilization review non-certified the request for C4 to C7 anterior cervical discectomy and fusion with bone band and plate as there was no description of dermatomal pain or paresthesia, no motor or reflex changes specific to a single or multiple myotomal levels, no documentation of Spurling's maneuver, and no indications of cervical myelopathy other than hyperreflexia which in and of itself was not pathognomonic of cervical myelopathy. The request for left carpal tunnel release was also non-certified, as the associated cervical surgery was not found medically necessary. The 6/15/15 treating physician appeal letter indicated that he was just requesting a left carpal tunnel release at this time, and was not planning on doing the two surgeries at the same time. The injured worker also needed the C4-C7 anterior cervical discectomy and fusion, but at a later time.

IMR ISSUES, DECISIONS AND RATIONALES

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

C4 to C7 anterior cervical discectomy and fusion with bone bank bone and plate: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 180-181.

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, Fusion, anterior 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) provide specific indications. The ODG recommend anterior cervical fusion as an option with anterior cervical discectomy if clinical indications are met. 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. Guideline criteria have not been met. This injured worker presents with current complaints documented as numbness and tingling in his left hand. There is no current documentation of a cervical radicular pain pattern or positive Spurling's test. Clinical exam findings did not evidence a focal motor or reflex deficit. Reflexes are reported as 1+ throughout. There is no electrodiagnostic evidence of cervical radiculopathy.

There is imaging evidence of severe neuroforaminal stenosis. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial for the neck and failure has not been submitted. Recent carpal tunnel release has relieved symptoms on the right side and a left carpal tunnel release has been requested for the residual left symptoms. There is no compelling rationale or clinical findings to support the medical necessity of proceeding with cervical spine surgery at this time. Therefore, this request is not medically necessary.