

Case Number:	CM15-0132039		
Date Assigned:	07/20/2015	Date of Injury:	01/03/1992
Decision Date:	09/22/2015	UR Denial Date:	07/07/2015
Priority:	Standard	Application Received:	07/08/2015

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 54-year-old female who sustained an industrial injury on 1/3/92. Injury occurred when she fell backwards while pulling out a cabinet drawer. Past medical history was positive for hypertension, diabetes mellitus, depression, reflux disease, hiatal hernia, and fibromyalgia. Past surgical history was positive for mitral valve surgery, gastric bypass, hernia repair, knee surgery and gall bladder/bile duct surgery. The 3/21/14 cervical spine MRI impression documented multilevel cervical degenerative disc disease. At C6/7, there was moderate to severe right foraminal narrowing and borderline central canal stenosis (9-10 AP). There was spinal canal stenosis at C5/6 with the central canal measuring 7 mm AP. There was contact upon and flattening of the ventral margin of the cervical cord at this level, greatest left anterolaterally. There was moderate to severe left and moderate right foraminal narrowing at this level. There was spinal canal stenosis at C4/5 with the central spinal canal measuring 7.3 mm AP. There was mild/borderline central canal stenosis at C3/4. Findings documented that there was no convincing abnormal signal in the cervical cord. The 11/21/14 bilateral upper extremity electrodiagnostic study documented evidence of a mild demyelinating and axonal median sensory neuropathy at the right wrist (carpal tunnel syndrome) without on-going denervation. There was no electrodiagnostic evidence of a left or right upper extremity plexopathy or neuropathy. EMG findings were reported normal. The 2/26/15 emergency department report indicated that the injured worker presented with severe bilateral neck and arm pain, headaches, and back pain. There was no recent history of trauma. She was on multiple pain medications and had trigger point injections today with increased pain to her neck and

body. Over the past several years, she had become debilitated with paralysis to her legs, urinary incontinence requiring self-catheterizations, and currently trying to get insurance approval for surgery. Physical exam documented pre-existing weakness to both lower extremities with decreased sensation bilaterally. Upper extremities were painful to touch but there was no motor or sensory deficits. The diagnosis was cervical radiculopathy. She was given injections of morphine and ketorolac. The 6/26/15 treating physician report indicated that the injured worker was last seen 7 months ago. She reported constant severe grade 10+/10 and worsening neck pain radiating to the right arm and hand (all fingers). She complained of numbness and tingling of the right arm into the fingers with weakness. She reported constantly dropping objects and no strength in her arm. Symptoms were exacerbated by turning the head to the left and with neck flexion. She was now experiencing bowel/bladder dysfunction including urgency, leakage and retention. She reported that she fell in December on a glass table and presented to the ER in the past two weeks due to uncontrollable pain. Symptoms were relieved by rest and non-steroidal anti-inflammatory drugs. She was unable to perform activities of daily living or house work. Past treatment had included NSAIDs, massage and physical therapy. She had a spinal cord stimulator. Physical exam documented no posterior cervical and lumbar tenderness, Spurling's test was negative. She was unable to heel/toe walk. There was 4/5 wrist extensor weakness bilaterally. Sensory exam was intact. She had diminished bilateral triceps reflexes. Deep tendon reflexes were equal and symmetrical in the lower extremities. There was no evidence of Hoffman, clonus or Babinski signs. Straight leg raise and contralateral straight leg raise was negative. Cervical spine x-rays were obtained and showed multilevel stenosis. Imaging showed multilevel stenosis with myelomalacia most notable from C4-C7. EMG was reported consistent with radiculopathy. The treatment plan recommended anterior cervical discectomy and fusion from C4-C7. Authorization was requested for neck spine disk surgery, neck spine disk surgery each additional space, neck spine fusion, 3 graft repair of spine defect, insert spine fixation device-anterior instrumentation, and 3 application of spine prosthetic device-application of intervertebral biomechanical devices. The 7/7/15 utilization review non-certified the comprehensive request for cervical spine surgery as there was no electrodiagnostic evidence of cervical radiculopathy, laterality of signs/symptoms did not fully correlate with imaging, and there was no documentation that carpal tunnel syndrome, thoracolumbar surgery or metabolic disorders had been fully ruled-out as the course of symptoms.

IMR ISSUES, DECISIONS AND RATIONALES

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

Neck spine disk surgery: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 179-180.

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.

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 indications for anterior cervical discectomy that 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 percent pain relief for the duration of the local anesthetic. Guideline criteria have not been fully met. This injured worker presents with constant severe neck pain radiating down the right arm into the hand and all fingers. There is no clearly radicular pain or sensory distribution pattern. She reported dropping things and no strength. She also complained of bowel/bladder dysfunction. Clinical exam findings documented wrist extension weakness bilaterally and diminished triceps reflexes bilaterally. Spurling's and pathologic reflex tests were negative. There was no electrodiagnostic evidence of radiculopathy, findings were positive for mild right carpal tunnel syndrome. There was imaging evidence of multilevel cervical stenosis with cord flattening at C5/6 but there was no abnormal cord signal abnormality. The injured worker reportedly had a spinal cord stimulator with no discussion as to thoracolumbar diagnosis, prior surgical history, or pre-existing issues relative to neurogenic bladder. She had a history of psychological symptoms with no evidence of psychological screening. There was a history of recent trauma with no documentation of a change in symptoms, findings, or updated imaging. Given the lack of comprehensive history of injury and treatment, the medical necessity of this request cannot be fully established. Therefore, this request is not medically necessary at this time.

Neck spine disk surgery each additional space: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 179-180.

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, Discectomy-laminectomy-laminoplasty.

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 indications for anterior cervical discectomy that 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 percent pain relief for the duration of the local anesthetic. Guideline criteria have not been fully met. This injured worker

presents with constant severe neck pain radiating down the right arm into the hand and all fingers. There is no clearly radicular pain or sensory distribution pattern. She reported dropping things and no strength. She also complained of bowel/bladder dysfunction. Clinical exam findings documented wrist extension weakness bilaterally and diminished triceps reflexes bilaterally. Spurling's and pathologic reflex tests were negative. There was no electrodiagnostic evidence of radiculopathy, findings were positive for mild right carpal tunnel syndrome. There was imaging evidence of multilevel cervical stenosis with cord flattening at C5/6 but there was no abnormal cord signal abnormality. The injured worker reportedly had a spinal cord stimulator with no discussion as to thoracolumbar diagnosis, prior surgical history, or pre-existing issues relative to neurogenic bladder. She had a history of psychological symptoms with no evidence of psychological screening. There was a history of recent trauma with no documentation of a change in symptoms, findings, or updated imaging. Given the lack of comprehensive history of injury and treatment, the medical necessity of this request cannot be fully established. Therefore, this request is not medically necessary at this time.

Neck spine fusion: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 180-183.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back, 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. Guideline criteria have not been met for cervical discectomy, therefore this request for cervical fusion is not medically necessary.

3 graft repair of spine defect: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 179-183.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back, Fusion, Anterior cervical.

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

1 insert spine fixation device/anterior instrumentation: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 179-183.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back, Fusion, anterior cervical.

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

3 application of spine prosthetic device/application of intervertebral biomechanical device(s): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 179-183.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back, Fusion, Anterior cervical.

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