

Case Number:	CM15-0132713		
Date Assigned:	07/20/2015	Date of Injury:	10/31/2007
Decision Date:	08/14/2015	UR Denial Date:	06/25/2015
Priority:	Standard	Application Received:	07/09/2015

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 58-year-old male who sustained an industrial injury on 10/31/07. The mechanism of injury was not documented. Past surgical history was positive for brain tumor resection, multiple bilateral shoulder surgeries, bilateral carpal tunnel release, right knee arthroscopy, and spinal cord stimulator implantation. Past medical history was positive for deep vein thrombosis, hypertension, cancer, left ventral hypertrophy, diabetes mellitus, and gastritis. The 4/6/15 cervical spine CT scan impression documented degenerative changes of the cervical spine. At C4/5, there was a disc bulge, uncovertebral hypertrophy, and mild ligamentum flavum hypertrophy causing moderate spinal canal stenosis and mild right neuroforaminal narrowing. At C5/6, there a disc osteophyte complex, uncovertebral hypertrophy, and mild ligamentum flavum hypertrophy causing moderate spinal canal stenosis and moderate to severe right and mild left neuroforaminal narrowing. At C6/7, there was a disc bulge and mild ligamentum flavum hypertrophy without significant spinal canal stenosis or neuroforaminal narrowing. The 6/1/15 electrodiagnostic study evidenced chronic right C6/C7 radiculopathies. The 6/17/15 spine surgery report cited severe neck pain associated with headaches, and pain radiating down both arms to the hands with associated paresthesias and weakness. Recent conservative treatment had included therapeutic injections, acupuncture, and medications with limited relief. Physical exam documented mildly antalgic gait, ability to heel/toe raise bilaterally, intact upper extremity sensation, 5/5 upper extremity motor strength, and 1 to 2+ and symmetrical deep tendon reflexes. There was no ankle clonus or crossed adductor reflexes, and Hoffman signs were absent. Lhermitte's and Spurling's signs were absent. Cervical range of motion was slightly decreased and tender posteriorly. Imaging demonstrated stenosis and neuroforaminal narrowing most impressive at C4/5 and C5/6, with no significant pathology at C6/7. The spine surgeon indicated that his neck and upper extremity symptoms may be a consequence of structural disease seen in his neck, but his orthopedic injuries and carpal tunnel syndrome could be contributing as well.

His arm symptoms may be mostly due to radiculopathy, but early myelopathy could not be excluded. The injured worker was felt to be a suboptimal but reasonable candidate for anterior cervical discectomy, fusion, and plating at C4/5 and C5/6. Authorization was requested for anterior cervical decompression and fusion (ACDF) at C4-C6. The 6/25/15 utilization review non-certified the request for ACDF at C4-C6 as the submitted documentation did not reflect objective evidence of a focal neurologic dysfunction that corroborate diagnostic findings.

IMR ISSUES, DECISIONS AND RATIONALES

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

Anterior cervical and fusion C4-C6: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back Chapter.

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. The ODG indicates that plate fixation is under study in single-level and multilevel procedures, with most studies (although generally non-randomized) encouraging use in the latter. Guideline criteria have not been met. This injured worker presents with severe neck pain radiating down both arms with paresthesias and weakness, and associated headaches. Spurling's test was negative. There is electro diagnostic evidence of C6 and C7 radiculopathy with imaging evidence of moderate stenosis at the C4/5 and C5/6 levels. However, there are no clinical exam findings of sensory loss, motor deficit or reflex change corroborating diagnostic findings. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. Therefore, this request is not medically necessary at this time.