

Case Number:	CM15-0135065		
Date Assigned:	07/23/2015	Date of Injury:	10/14/2011
Decision Date:	08/21/2015	UR Denial Date:	06/24/2015
Priority:	Standard	Application Received:	07/13/2015

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 51-year-old male who sustained an industrial injury on 10/14/11. Injury occurred when he was placing covers on cars that were on a trailer, slipped and fell 7-10 feet. He hit his face against the trailer and then hit the ground. He experienced loss of consciousness and was transported to the hospital by ambulance. He was diagnosed with subdural hematoma, facial fractures, chipped and broken teeth, left wrist sprain, and multiple bruises. The 1/21/15 bilateral upper extremity EMG/NCV report documented left severe and right borderline sensory median neuropathy at the wrist. There was no electrodiagnostic evidence suggestive of cervical and thoracic radiculopathy. The 12/17/14 treating physician report documented the impression of the 11/17/14 cervical spine MRI. At C3/4, there was a 4 mm disc protrusion that moderately flattened the right ventral cord and moderately narrowed the canal. There was mild bilateral neuroforaminal narrowing. At C4/5, there was a 3 mm annular disc bulge that mild to moderately flattened the cord, and mild to moderate canal narrowing. There was uncinete hypertrophy extending into the neural foramen with moderate left neuroforaminal narrowing. At C5/6, there was a 3-4 mm disc herniation with osteophyte, which moderately flattened the cord, and moderately narrowed the canal. There was uncinete hypertrophy extending into the neural foramen with facet hypertrophy and moderate to severe left and mild right neuroforaminal narrowing. At C6/7, there was a 2-3 mm disc herniation that mildly flattened the anterior thecal sac without indenting the cord. There was mild bilateral neuroforaminal narrowing, and moderate facet hypertrophy with mild to moderate right and moderate to severe left neuroforaminal narrowing. At C7/T1, there as right greater than left facet hypertrophy with mild

right neuroforaminal narrowing. The 2/2/15 treating physician report indicated that the injured worker had completed extensive non-operative treatment including various therapies and medication without sustained relief. He was not interested in cervical epidural steroid injections. He had multilevel cervical disc herniation, and severe left neuroforaminal stenosis at C5/6 and C6/7. The treatment plan included C5/6 and C6/7 anterior cervical discectomy and fusion with instrumentation and bone graft. The 5/7/15 treating physician report cited increased neck and bilateral radicular pain with worsening numbness and tingling in the bilateral upper extremities. The injured worker reported pain, numbness and tingling in the left wrist. Cervical spine range of motion testing documented moderate to marked limitation of motion in all planes. Neurologic upper extremity exam documented decreased sensation over the entire right hand, 4/5 bilateral shoulder flexion weakness, and negative neuroforaminal compression testing bilaterally. The diagnosis included C5/6 moderate disc herniation with moderate canal narrowing and severe left and mild right neuroforaminal narrowing, and C6/7 small shoulder with mild canal narrowing with severe left and moderate right neuroforaminal narrowing. The treating physician report noted a pending request for treatment of the injured worker's carpal tunnel syndrome, and denial of the requested C5/6 and C6/7 discectomy and fusion. The injured worker was having a flare-up of his condition and physical therapy was recommended. The treatment plan also recommended an increase in his Norco dose and gabapentin to manage his neuropathic pain. Authorization was requested for discectomy and fusion at C5-C7 with instrumentation and bone graft. The 6/24/15 utilization review non-certified the request for C5-C7 discectomy and fusion with instrumentation and bone graft as there was an absence of clear clinical and imaging findings of cervical radiculopathy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Discectomy and fusion at C5-C7 with instrumentation and bone graft: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 180. Decision based on Non-MTUS Citation Official Disability Guidelines, 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; Plate fixation, cervical spine surgery.

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 understudy in single-level and multilevel procedures, with most studies (although generally non-randomized) encouraging use in the latter. It remains unclear as to whether anterior plating provides benefit for many common spondylotic conditions of the cervical spine. In single-level surgery there has been a failure to demonstrate an improvement in fusion rates with plating. Guideline criteria have been met. This injured worker presents with neck pain radiating into the upper extremities with worsening numbness and tingling. There is clinical exam evidence of a motor deficit consistent with imaging evidence of severe neuroforaminal narrowing and potential neurocompression at the C5/6 and C6/7 levels. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial for the neck and failure has been submitted. Imaging additionally shows multilevel cord flattening from C3/4 to C5/6. Therefore, this request is medically necessary at this time.