

Case Number:	CM15-0149894		
Date Assigned:	08/13/2015	Date of Injury:	04/16/2013
Decision Date:	09/29/2015	UR Denial Date:	07/20/2015
Priority:	Standard	Application Received:	08/03/2015

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 56-year-old male who sustained an industrial injury on 4/16/13. Injury occurred when he had his arm outstretched to stop a forklift that was coming towards him when he was impacted by the forklift resulting in injuries to his upper extremities, upper back, and neck. Conservative treatment included activity modification, medications, acupuncture, physical therapy, and epidural steroid injections. The 1/16/14 left shoulder MRI impression documented minimal tendinosis of the rotator cuff tear with no tear. There was a posterolateral labral tear with associated paralabral cyst and degeneration of the anterosuperior labrum. The 4/8/15 cervical spine MRI impression documented a 3 mm posterior and right intraforaminal C5/6 disc protrusion causing mild spinal canal and right neuroforaminal stenosis. At C6/7, there was 2-3 mm posterior and right intraforaminal C6/7 disc protrusion causing mild right neuroforaminal stenosis. There was 1 to 2 mm C3/4 and C4/5 posterior disc bulges. There was mild to moderate spondylosis from C3 to C7. The 5/21/15 spine surgery report cited grade 8/10 neck pain radiating into the left arm with numbness, tingling, and significant weakness. He reported marked limitation in left arm use. Physical exam documented 3/5 weakness in left shoulder forward elevation and rotation, left shoulder forward elevation to 70 degrees, and diminished bilateral sensation. X-rays were obtained and showed collapse with spur formation at C4/5, C6/7, and C6/7. Imaging showed significant C4-C7 central canal stenosis, moderate bilateral C4/5 foraminal stenosis, moderate C5/6 spinal stenosis, and severe bilateral C6/7 spinal stenosis. The diagnosis was spinal stenosis at C4/5, C5/6, and C6/7 with left arm radiculopathy and possible cubital tunnel syndrome. Shoulder MRI demonstrated some tendinosis but no rotator cuff tear. Surgery was recommended to include C4-C7 anterior cervical discectomy and fusion with allograft bone graft and plate fixation. The 7/1/15 treating physician report cited neck and left

shoulder, elbow, wrist, and hand pain. Physical exam documented tenderness to palpation over the cervical midline, left trapezius, levator scapulae, medial and lateral epicondyle, and dorsal and volar wrist. There was pain in cervical flexion/extension, positive Neer's and Hawkin's tests, and hand weakness. The treatment plan recommended C4 to C7 anterior cervical discectomy and fusion per the spine surgeon report of 5/21/15. Authorization was requested for C3-C7 anterior cervical discectomy and fusion with allograft bone graft and plate fixation. The 7/16/15 utilization review non-certified the request for C3-C7 anterior cervical discectomy and fusion with allograft bone graft and plate fixation as there was not enough clinical documentation or clinical notes from the spine surgeon to support the medical necessity of this request.

IMR ISSUES, DECISIONS AND RATIONALES

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

C3-C7 Anterior Cervical Discectomy and Fusion with Allograft Bone Graft and Plate Fixation: Upheld

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 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) provides 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. Etiologies of pain such as metabolic sources (diabetes/thyroid disease) non-structural radiculopathies (inflammatory, malignant or motor neuron disease), and/or peripheral sources (carpal tunnel syndrome) should be addressed prior to cervical surgical procedures. Guideline criteria have not been met. This injured worker presents with neck pain radiating into the left arm with numbness, tingling and weakness. There is imaging evidence of cervical multilevel spinal stenosis with no specific nerve root compression documented. There is also imaging evidence of rotator cuff tendinosis and labral pathology. Clinical exam findings do not evidence definitive cervical nerve root compression at multiple levels. There was no electrodiagnostic

study available for review. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. There is no evidence that all etiologies of pain have been ruled-out, including shoulder and cubital tunnel. Therefore, this request is not medically necessary at this time.