

Case Number:	CM15-0163016		
Date Assigned:	08/31/2015	Date of Injury:	08/15/2013
Decision Date:	10/05/2015	UR Denial Date:	07/24/2015
Priority:	Standard	Application Received:	08/19/2015

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: California, Oregon, Washington
 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:

The injured worker is a 43-year-old female, who sustained an industrial injury on August 15, 2013. Treatment to date has included diagnostic imaging, cervical epidural steroid injection, physical therapy, chiropractic therapy, work restrictions and medications. Currently, the injured worker complains of cervical spine pain with radiation of pain to the bilateral upper extremities. She reports headache and pain in the right shoulder, upper arm, forearm, elbow and hand. She rates her cervical spine pain a 9 on a 10-point scale, her headaches a 10 on a 10-point scale, and her right upper extremity pain an 8 on a 10-point scale. She has associated weakness and numbness in the neck and hands and has tingling in the neck. Her pain is aggravated with overhead reaching, lifting, pushing, and pulling. On physical examination, the injured worker has tenderness to palpation over the cervical spine and decreased range of motion in all planes. She has decreased muscle strength and decreased sensation in the C6 and C7 dermatomes. An MRI of the cervical spine on December 8, 2014 revealed mild multi-level degenerative disease of the cervical spine, normal cervical spine cord signal intensity and posterior disc osteophyte complex, bilateral uncovertebral and facet joint hypertrophy, moderate spinal canal stenosis and moderate bilateral foraminal narrowing of C5-6. The diagnoses associated with the request include cervical spine disc protrusion with bilateral upper extremities radiculopathy and bilateral upper extremities weakness. The treatment plan includes anterior cervical discectomy with fusion at C5-C6, assistant surgeon, preoperative medical clearance, and post-operative cervical brace, bone stimulator purchase, cold therapy unit, and physical therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Anterior cervical discectomy and fusion at C5-C6: Overturned

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 181-183.

Decision rationale: Per the CA MTUS/ACOEM guidelines, Neck and upper back complaints, pages 181-183 surgery is not recommended for non-radiating pain or in absence of evidence of nerve root compromise. There is evidence of correlating nerve root compromise from the exam of 1/7/15 and the MRI from 12/8/14. The patient has radiating pain from the exam notes and this does correlate with the imaging findings. Therefore, the patient does meet accepted guidelines for the procedure and the request is certified. Per the CA MTUS/ACOEM guidelines, Chapter 8, Neck and Upper Back complaints, pages 180-193 states that surgical consultation is indicated for persistent, severe and disabling shoulder or arm symptoms who have failed activity limitation for more than one month and have unresolved radicular symptoms after receiving conservative treatment. In this case, the exam notes from 1/7/15 do demonstrate conservative treatment has been performed for the claimant's cervical radiculopathy. Therefore, the determination is medically necessary.

Associated surgical services: Assistant surgeon: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back Chapter, Surgical Assistant; AAOS Position Statement Reimbursement of the First Assistant at Surgery in Orthopaedics (<http://www.aaos.org/about/papers/posotion/1120.asp>).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) low back.

Decision rationale: CA MTUS/ACOEM is silent on the issue of assistant surgeon. According to the ODG, Low Back Chapter, Surgical assistant is recommended as an option in more complex surgeries including CPT code 22554, an ACDF. As the surgical request CPT code is recommended for assistant surgeon, the determination is medically necessary.

Associated surgical services: Preoperative medical clearance: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back - Lumbar & Thoracic; Guidance on Peri-operative Cardiovascular Evaluation and Management of Patients Undergoing Non-cardiac Surgery. A report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) low back.

Decision rationale: CA MTUS/ACOEM is silent on the issue of preoperative clearance and testing. ODG, Low back, Preoperative testing general, is utilized. This chapter states that preoperative testing is guided by the patient's clinical history, comorbidities and physical examination findings. ODG states, "These investigations can be helpful to stratify risk, direct anesthetic choices, and guide postoperative management, but often are obtained because of protocol rather than medical necessity. The decision to order preoperative tests should be guided by the patient's clinical history, comorbidities and physical examination findings. Patients with signs or symptoms of active cardiovascular disease should be evaluated with appropriate testing, regardless of their preoperative status." Preoperative ECG in patients without known risk factor for coronary artery disease, regardless of age, may not be necessary. CBC is recommended for surgeries with large anticipated blood loss. Creatinine is recommended for patient with renal failure. Electrocardiography is recommended for patients undergoing high-risk surgery and those undergoing intermediate risk surgery who have additional risk factors. Patients undergoing low risk surgery do not require electrocardiography. Based on the information provided for review, there is no indication of any of these clinical scenarios present in this case. In this case the patient is a healthy 43 year old without comorbidities or physical examination findings concerning to warrant preoperative testing prior to the proposed surgical procedure. Therefore, the determination is for non-certification. CA MTUS ACOEM/ODG are silent with regard to the use or preoperative chest x-rays. Alternate guidelines are referenced. In an article entitled "Preoperative Testing before Non-cardiac Surgery: Guidelines and Recommendations: which was published in the American Family Physician 2013, Feely et al stated that: Chest radiography is reasonable for patients at risk of postoperative pulmonary complications if the results would change perioperative management." There is no documentation in the provided medical records that this patient is at a higher risk for postoperative pulmonary complications and thus the request for a preoperative chest x-ray is not considered to be medically necessary.

Associated surgical services: Post operative physical therapy x 24 per medical report:
Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s):
26.

Decision rationale: Per the CA MTUS/Post Surgical Treatment Guidelines, page 26 recommends the following: Postsurgical treatment (fusion, after graft maturity): 24 visits over 16 weeks. The guidelines recommend initially of the 12 visits to be performed. As the request exceeds the initial allowable visits, the determination is not medically necessary.

Associated surgical services: Cervical brace: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 181-183. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) neck section.

Decision rationale: CA MTUS/ACOEM is silent on the issue of cervical collars. Per ODG, Neck section, cervical collars, post operative (fusion), "Not recommended after single-level anterior cervical fusion with plate. The use of a cervical brace does not improve the fusion rate or the clinical outcomes of patients undergoing single-level anterior cervical fusion with plating. Plates limit motion between the graft and the vertebra in anterior cervical fusion. Still, the use of cervical collars after instrumented anterior cervical fusion is widely practiced. This RCT found there was also no statistically significant difference in any of the clinical measures between the Braced and Non-braced group. The SF-36 Physical Component Summary, NDI, neck, and arm pain scores were similar in both groups at all time intervals and showed statistically significant improvement when compared with preoperative scores. There was no difference in the proportion of patients working at any time point. Independent radiologists reported higher rates of fusion in the non-braced group over all time intervals, but those were not statistically significant." As the guidelines do not support bracing postoperatively, the determination is not medically necessary.

Associated surgical services: Bone stimulator purchase: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Bone Growth Stimulators (BGS).

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.

Decision rationale: CA MTUS/ACOEM is silent on the issue of bone growth stimulator for the cervical spine. According to the ODG Neck and Upper Back, it is under study. An alternative Guideline, the low back chapter was utilized. This chapter states that bone growth stimulator would be considered for patients as an adjunct to spine fusion if they are at high risk. In this case, the fusion proposed is at one level and there is no high risk factors demonstrated in the records submitted. Therefore, determination is not medically necessary.

Associated surgical services: Cold therapy unit rental: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Continuous-flow cryotherapy.

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.

Decision rationale: CA MTUS/ACOEM is silent on the issue of continuous flow cryotherapy. According to the ODG Neck and Upper back regarding continuous flow cryotherapy, it is not recommended in the neck. Local application of cold packs is recommended by the ODG Neck and Upper Back section. Therefore, determination is not medically necessary for the requested cold therapy vascultherm post surgical procedure.