MAXIMUS Federal Services

Case Number:	CM15-0180883		
Date Assigned:	09/22/2015	Date of Injury:	06/25/2012
Decision Date:	10/26/2015	UR Denial Date:	09/08/2015
Priority:	Standard	Application Received:	09/14/2015

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 59-year-old male who sustained an industrial injury on 6/25/12. Injury occurred when he was working on a malfunctioning elevator and the elevator dropped 4-15 feet, resulting in neck pain. Past surgical history was positive for anterior and posterior L4-S1 fusion in 1986. Conservative treatment had included C6/7 epidural steroid injection, chiropractic treatment, activity modification, home exercise, and medications. The 10/16/12 electrodiagnostic study was reported as incomplete. The needle study was deferred as the injured worker was taking daily Warfarin. There was evidence of left ulnar motor neuropathy at the elbow. Findings also suggested bilateral S1 nerve root involvement. The 3/17/15 cervical spine MRI impression documented endplate degenerative changes at C6/7 associated with disc space narrowing. Findings at C6/7 documented posterior ridging causing minimal central canal stenosis and uncinate joint spurs causing mild to moderate right neuroforaminal narrowing. There was mild central canal stenosis and mild right neuroforaminal narrowing at C4/5 from a small disc protrusion, posterior ridging and uncinate joint spurs. There was minimal central canal stenosis at C5/6 from posterior ridging and disc bulging. The 8/19/15 treating physician report cited persistent neck and back pain, increased 20% since his last appointment. Neck pain was reported grade 8/10 and radiating into the bilateral trapezius muscles with right greater than left numbness. He reported that he was dropping things out of his hands. He had left shoulder pain, increased with overhead reaching. He also reported low back pain radiating into the left lower extremity to the foot with pins/needles. He reported difficulty sleeping due to pain. He was working modified duty. He reported 40-50% pain relief with Norco during the day, and

Norflex helped him fall asleep at night. Physical exam documented antalgic gait, difficulty with toe/heel walk, and generalized spinal tenderness to palpation. Sensation was diminished over the left C6, C7, and C8 dermatomes. Motor strength was documented 4+/5 over left deltoid, biceps, internal rotation, external rotation, wrist extension, and wrist flexion. There were diminished deep tendon reflexes over the upper and lower extremities. Spurling's test was positive on the left with pain radiating to the left elbow. The diagnosis included multilevel cervical disc herniations with moderate to severe neuroforaminal narrowing, facet arthropathy, and cervical radiculopathy. Authorization was requested for an interlaminar epidural steroid injection at C6/7. He was to continue on his home exercise program. Medications were continued. The 8/24/15 treating physician report cited continued worsening of his neck and upper extremity symptoms. He complained of aching grade 8/10 neck pain radiating into his trapezius muscles with upper extremity numbness, greater on the left. He reported that he was frequently dropping things and that his grip was weaker. Physical exam was unchanged relative to 8/19/15. The treating physician documented a discussion of various treatment options. He indicated that the injured worker had severe degenerative disc disease at C6/7 with nerve compression. Authorization was requested for a 23-hour outpatient C6/7 anterior cervical discectomy and fusion (ACDF). The 9/8/15 utilization review non-certified the request for 23-hour outpatient C6/7 ACDF as there was no indication of acute compressive pathology at the C6/7 level with clinical correlation between physical exam findings and imaging.

IMR ISSUES, DECISIONS AND RATIONALES

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

23 hours outpatient C6-C7 ACDF: Overturned

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back Chapter, Criteria for Cervical Fusion.

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Surgical Considerations. 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. Guideline criteria have been met. This injured worker presents with persistent neck pain radiating into the trapezius muscles with numbness in the upper extremities, worse on the left. He reported functional difficulty in grip strength. There is a positive Spurling's test. Clinical exam findings documented sensory changes in the left C6-C8 distribution, focal motor and reflex changes documented in the clinical exam. Imaging evidences findings of plausible nerve root compromise correlated with clinical exam. Reasonable non-operative treatments of at least medications and altered activities have been tried and failed. Therefore, this request is medically necessary at this time.