

Case Number:	CM15-0189706		
Date Assigned:	10/01/2015	Date of Injury:	06/26/2014
Decision Date:	11/10/2015	UR Denial Date:	09/15/2015
Priority:	Standard	Application Received:	09/25/2015

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 63-year-old male who sustained an industrial injury on 6/26/14. Injury occurred when the vehicle he was driving was struck on the driver's side. Past medical history was positive for hypertension. Social history was positive for smoking one pack of cigarettes per day. The 5/20/15 agreed medical examiner report documented a claim for injuries to the neck, low back and left shoulder. Conservative treatment had included 6 sessions of physical therapy in July 2014 and 6 sessions 9 months later. He had just initiated chiropractic treatment with 4 sessions to date. He was working full duty and scheduled to retire in August 2015. Current complaints included neck pain with tiredness, stiffness, limited motion, and occasional numbness, throbbing low back pain and occasional spasms, and left shoulder pain and swelling. He denied radiation of neck pain but reported occasional numbness and tingling in the upper extremities. Cervical spine exam documented mild loss of cervical range of motion, no upper extremity sensory loss, brisk and symmetrical deep tendon reflexes, and no upper extremity weakness. Grip strength was symmetrical. Cervical spine x-rays revealed severe C4-C7 degenerative disc disease. Future medical treatment included access to an orthopedic surgeon, further diagnostic testing, and access to medications. The 7/9/15 progress report cited on-going low back pain with numbness in the left foot, on-going neck pain with numbness in the left upper extremity predominantly at nighttime, and shoulder pain, left worse than right. He also reported dizziness and blurred vision. He reported minimal benefit with chiropractic therapy but significant benefit with prior physical therapy. Upper extremity neurologic exam documented normal sensation and motor function. The treatment plan recommended additional physical

therapy treatment for complaints of neck, low back and bilateral shoulder pain. Cervical, lumbar, and left shoulder MRIs were recommended, as the injured worker remained symptomatic despite medication, therapy, and a home exercise program for nearly one year with no diagnostic studies. Bilateral upper and lower extremity EMG/NCV was recommended as the patient had persistent left upper and lower extremity pain and numbness. Authorization was requested for anterior cervical discectomy and fusion at C4/5 and C5/6. The 9/15/15 utilization review non-certified the request for anterior cervical discectomy and fusion at C4/5 and C5/6 as there the findings of a myelopathy were soft, non-operative management was not documented, and the patient was a smoker with no evidence of cessation. Records documented MRI findings of severe stenosis secondary to degenerative joint disease and disc herniations at C4-C6 with mild osteoarthritis noted at c2 and C6/7.

IMR ISSUES, DECISIONS AND RATIONALES

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

Anterior discectomy and fusion at C4-C5, C5-C6: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, (ODG) Anterior Cervical Discectomy.

MAXIMUS guideline: Decision based on MTUS Low 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. Because of the high risk of pseudoarthrosis, a smoker anticipating a spinal fusion should adhere to a tobacco-cessation program that results in abstinence from tobacco for at least six weeks prior to surgery. Guideline criteria have not been met. This injured worker presents with persistent neck pain with numbness into the left upper extremity. Clinical exam findings did not evidence motor deficit or reflex changes, and there was no documentation of a positive Spurling's test. There is no documentation of a positive selective nerve root block. An imaging or electrodiagnostic report was not submitted for review. Records document that imaging findings showed degenerative joint disease and disc herniations at the C4-to C6 levels with severe stenosis. Detailed evidence of a recent,

reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. Additionally, this injured worker is reported to be a smoker with no documentation of smoking cessation consistent with guideline recommendations. Therefore, this request is not medically necessary.