

Case Number:	CM15-0200081		
Date Assigned:	10/15/2015	Date of Injury:	08/17/2013
Decision Date:	11/24/2015	UR Denial Date:	09/30/2015
Priority:	Standard	Application Received:	10/12/2015

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 57-year-old female who sustained an industrial injury on 6/17/13, relative to a trip and fall. Records indicated that she was diagnosed with a right elbow fracture, right shoulder tear, right thumb/wrist tears, and contusions to the face and knee. She underwent right shoulder arthroscopic surgery with decompression and Mumford procedure on 3/11/14, right lateral epicondylar release on 6/24/14, and right thumb anchovy procedure on 9/9/14. The 9/26/13 cervical spine MRI impression documented broad based disc protrusion at C3/4 that abutted the thecal sac and combined with facet and unciniate arthropathy, resulting in bilateral neuroforaminal narrowing. At C4/5, there was grade 1 spondylolisthesis of C4/5 that measured 2 mm in neutral and flexion and reduced to 0 mm in extension. Combined with a disc protrusion and facet unciniate hypertrophy, there was spinal canal narrowing and left greater than right neuroforaminal narrowing. At C5/6, there was a broad-based disc protrusion abutting the thecal sac and combined with facet and unciniate arthropathy, there was bilateral neuroforaminal narrowing. The 4/24/15 psychiatric evaluation report diagnosed a depressive disorder and recommended psychotherapy. The 8/27/15 occupational medicine report cited grade 7/10 right elbow, hand, and shoulder pain. Pain was increased with lifting, everyday chores, physical therapy, and moving heavy objects. Alleviating factors included rest and medications. She complained of worsening anxiety. Physical exam documented tenderness to palpation over the right posterior shoulder, deltoid, trapezium, and acromioclavicular joint. Right shoulder exam documented decreased range of motion and strength, and positive impingement sign. The diagnosis included cervical and thoracic sprain/strain, shoulder and knee/leg sprain/strain,

lateral epicondylitis, wrist sprain/strain, and effusion of upper arm joint. Dental follow-up was recommended for a broken bridge screw. Medications were dispensed including gabapentin, ibuprofen, pantoprazole, and Ultracin pain relief lotion. The 9/18/15 spine surgery report cited right shoulder pain and neck pain radiating into the right upper extremity to the thumb. The injured worker reported minimal improvement despite anti-inflammatories, physical therapy, injection, right shoulder surgery, and right carpal tunnel release. Review of systems documented complaints of depression. Physical exam documented cervical paraspinal muscle tenderness to palpation, full cervical range of motion, diminished right C6 dermatome, and normal upper extremity strength and deep tendon reflexes. Imaging showed C5 to C6 disc herniation with disc collapse. The diagnosis included right shoulder arthritis and cervical radiculopathy. Neurologic deficit was concordant with imaging findings. Authorization was requested for anterior cervical discectomy and fusion at the C5/6 level. The 9/30/15 utilization review non-certified the request for anterior cervical discectomy and fusion at C5/6 as recent imaging studies, a pre-operative psychological evaluation, and specific objective findings such as motor deficits and positive provocative testing to support the diagnosis of cervical radiculopathy were not provided.

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 the C5-C6 levels: Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation Official Disability Guidelines: Neck & Upper Back - Criteria for cervical fusion.

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: 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) 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. Guidelines state that 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 complaints of neck and right upper extremity pain.

There is no clear radicular pattern documented or evidence of a positive Spurling's test. There is evidence of sensory change in the C6 distribution, but no clinical exam evidence of motor deficit or reflex changes correlated with the requested surgical level. There is imaging evidence of multilevel cervical disc pathology with plausible nerve root compression. There is no electrodiagnostic study or positive selective nerve root block documented. Additionally, there are multiple right upper extremity diagnoses and prior surgical interventions noted without evidence that other pain generators have been fully ruled-out. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial for the cervical spine and failure has not been submitted. Potential psychological issues are documented with no evidence of psychological clearance for surgery. Therefore, this request is not medically necessary at this time.