

Case Number:	CM15-0020130		
Date Assigned:	03/17/2015	Date of Injury:	04/27/1964
Decision Date:	04/22/2015	UR Denial Date:	01/11/2015
Priority:	Standard	Application Received:	02/03/2015

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:

The injured worker is a 72-year-old male who sustained an industrial injury on 4/27/64. The specific mechanism of injury was not documented, but motorcycle accidents are noted. Past surgical history was positive for multiple lumbar spine surgeries, with a T10-S1 spinal fusion on 9/30/11. Past medical history was positive for remote C1 fracture, and a history of deep vein thrombosis of the left femoral popliteal views, previously treated with anticoagulant therapy and filter insertion. The 8/23/14 cervical spine MRI impression documented spinal canal narrowing that was moderate to severe at C4/5, mild to moderate at C3/4, and mild at C5/6 and C6/7. There was a focal faint T2 hyper-intensity signal within the spinal cord at C4 which may reflect mild cord edema or myelomalacia. There was multilevel foraminal narrowing that was reported to be moderate on the right at C5/6 and severe on the right at C6/7 and C7/T1, and mild on the left at all these levels. At C3/4, there was a 5 mm central disc protrusion with mild to moderate spinal canal narrowing and disc material indenting the anterior cord, and mild right and moderate left neuroforaminal narrowing. The 1/13/14 treating physician report cited intractable neck and upper back pain. He had failed acupuncture, physical therapy, and various pharmacological treatment. He had extreme problems with mobilization and was severely impeded in his ability to perform activities of daily living. An appeal for cervical surgery stated that the patient had clear cut neurologic findings with loss of motor strength in the upper extremities and diminished vibratory and light touch sensation. He was dropping things and had trouble opening jars. The 1/11/15 utilization review non-certified the request for bilateral C3/4 and C4/5 laminectomy and right C5/6, C6/7, and C7/T1 laminectomy and foraminotomy, and the associated requests for 3-day

inpatient stay, assistant surgeon, and pre-operative medical clearance with an internist. The rationale for non-certification noted complaints consistent with the C4/5 level only, and recent exam did not contain any positive orthopedic testing and the neurologic exam was reported normal, with no sensory or motor findings noted. Epidural steroid injection was only partially successful and psychology issues were noted with no clearance documented. The 3/16/15 treating physician report cited neck radiating right arm pain and numbness. Physical exam documented normal gait with normal upper extremity muscle strength and symmetrical 2+ deep tendon reflexes. Grip strength was 100 pounds left, 80 pounds right. There was patchy decreased sensation over the right forearm and dorsum of the right hand, 5th digit. The diagnosis was cervicalgia, cervical myelopathy at C4, cervical spinal stenosis at C3/4 and C4/5, and potential for cervical radiculopathy at multiple levels C5, right C7, and right T1. The injured worker had been treated with conservative treatment including physical therapy, acupuncture, analgesics, muscle relaxants and an anti-depressant.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral cervical 3-4 + 4-5 laminectomy; right cervical 5-6, 6-7 +C7-T1 laminectomy foraminotomy: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 180-181. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck & Upper Back (Acute & Chronic).

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.

Decision rationale: The California Medical Treatment Utilization Schedule guidelines provide a general recommendation for cervical decompression surgery, including consideration of pre-surgical psychological screening. The Official Disability Guidelines (ODG) provide specific indications. The ODG recommend laminectomy 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. Guideline criteria have been met. The patient presents with intractable neck pain radiating to the right upper extremity with numbness. There is severe impairment in activities of daily living noted. Clinical exam findings are consistent with imaging evidence of C4 myelopathy and multilevel neural compromise from C5/6 to C7/T1. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. Therefore, this request is medically necessary.

3 Day in-patient hospital stay: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck & Upper Back (Acute & Chronic).

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: Hospital length of stay (LOS).

Decision rationale: The California MTUS does not provide recommendations for hospital length of stay. The Official Disability Guidelines generally recommend the median length of stay (LOS) based on type of surgery, or best practice target LOS for cases with no complications. The best practice target for cervical laminectomy is 1 day. The median length of stay for cervical laminectomy is reported as 2 days, and the mean length of stay is 3.5 days. Given the multilevel cervical procedure being requested, it is reasonable to use the mean length of stay, which is 3 days. Therefore, this request is medically necessary.

Assistant surgeon: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Centers for Medicare and Medicaid services, Physician Fee Schedule Search <http://www.cms.gov/apps/physician-fee-schedule/overview.aspx>.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Centers for Medicare and Medicaid services Physician Fee Schedule Assistant Surgeons <http://www.cms.gov/apps/physician-fee-schedule/overview.aspx>.

Decision rationale: The California MTUS guidelines do not address the appropriateness of assistant surgeons. The Center for Medicare and Medicaid Services (CMS) provide direction relative to the typical medical necessity of assistant surgeons. The Centers for Medicare & Medicaid Services (CMS) has revised the list of surgical procedures, which are eligible for assistant-at-surgery. The procedure codes with a 0 under the assistant surgeon heading imply that an assistant is not necessary; however, procedure codes with a 1 or 2 implies that an assistant is usually necessary. For this requested surgery, CPT code 63045 and 63048, there is a "2" in the assistant surgeon column for each code. Therefore, based on the stated guideline and the complexity of the procedure, this request is medically necessary.

Pre op medical clearance with internist: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Surgery General Information and Ground Rules, California Official Medical Fee Schedule, 1999 edition, Page 92-93.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Institute for Clinical Systems Improvement (ICSI).

Preoperative evaluation. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2010 Jun. 40.

Decision rationale: The California MTUS guidelines do not provide recommendations for pre-operative medical clearance. Evidence based medical guidelines indicate that a basic pre-operative assessment is required for all patients undergoing diagnostic or therapeutic procedures. Guideline criteria have been met based on patient age, history of deep vein thrombosis, magnitude of surgical procedure, recumbent position, fluid exchange and the risks of undergoing anesthesia. Therefore, this request is medically necessary.