

Case Number:	CM15-0021535		
Date Assigned:	02/11/2015	Date of Injury:	04/01/2000
Decision Date:	04/03/2015	UR Denial Date:	01/13/2015
Priority:	Standard	Application Received:	02/04/2015

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: Minnesota, Florida
 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 54 year old male, who sustained an industrial injury on 4/1/2000. The current diagnoses are cervical radiculopathy, bilateral upper extremity weakness with intermittent paresthesia, dysphagia, cervicogenic headaches, and status post C5-C6 fusion (2003). Currently, the injured worker complains of neck pain with associated bilateral upper extremity radiculopathy. Current medications are Norco, Tramadol, Naproxen, Gabapentin, Cyclobenzaprine, Omeprazole, and Lisinopril. Treatment to date has included medications, physical therapy, epidural steroid injections, and surgery. The treating physician is requesting anterior cervical discectomy and fusion with instrumentation at the level of C4-C5 and C5-6 and removal of instrumentation at C5-C6, which is now under review. On 1/13/2015, Utilization Review had non-certified a request for anterior cervical discectomy and fusion with instrumentation at the level of C4-C5 and C5-C6 and removal of instrumentation at C5-C6. The California MTUS ACOEM and Official Disability Guidelines were cited.

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 with Instrumentation at the level of C4-C5 and C5-C6 and Removal of Instrumentation at 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) Low Back, Hardware implant removal (fixation).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 179, 180.

Decision rationale: California MTUS guidelines recommend surgical considerations for severe spinovertebral pathology and severe debilitating symptoms with physiologic evidence of specific nerve root or spinal cord dysfunction corroborated on appropriate imaging studies that did not respond to conservative therapy. The indications include persistent severe and disabling shoulder or arm symptoms with activity limitation for more than one month or with extreme progression of symptoms and clear clinical, imaging, and electrophysiologic evidence, consistently indicating the same lesion that has been shown to benefit from surgical repair in both the short and long-term and unresolved radicular symptoms after receiving conservative treatment. The documentation provided indicates a C5-6 anterior cervical discectomy and fusion was performed in the year 2003 and the injured worker has complaints of dysphagia since that time. The Orthopedic Spine Surgeon has recommended additional fusions above and below the level of the previous fusion for adjacent level disease and does not report any hardware failure as stated in the primary treating physician's progress report and request for authorization dated November 19, 2014. In fact, according to the surgeon, additional surgery is likely to make the dysphagia worse. Per exam of 11/19/2014 the injured worker has a history of low back pain as well as neck pain. Additional complaints include cramping and numbness in the lower extremities. The neck pain radiates to the shoulders. There is burning and tingling sensation in the arms and hands intermittently. Bilateral wrist and hand tingling were considered nonindustrial. He also has right knee pain due to a fall on 5/21/2013. In addition, he complains of headaches. On examination there was slight to moderate paracervical muscle spasm. Flexion of the cervical spine was reported to be 90% of normal and remaining movements were 60% of normal. Spurling sign was reported to be positive bilaterally. The examination does not document any sensory or motor neurologic deficit in the upper extremities. Deep tendon reflexes are also not documented. In addition, there was tenderness noted in the thoracic and lumbar area with positive straight leg raising in the seated position at 70 bilaterally. The diagnostic testing per primary treating physician's notes included an EMG on 3/13/2013 which showed slight chronic C6 motor radiculopathy on the left. Mild bilateral carpal tunnel syndrome was also noted. MRI of the cervical spine dated 5/30/2013 was reported to show status post anterior fusion at C5-6, moderate bilateral neural foraminal narrowing secondary to 1-2 mm posterior disc bulge and uncovertebral osteophyte formation at C2-3 level, bilateral neural foraminal narrowing secondary to 1-2 mm posterior disc bulge and uncovertebral osteophyte at C3-4 level, moderate to severe left and mild right foraminal narrowing secondary to 1-2 mm posterior disc bulge and uncovertebral osteophyte formation at C4-5 level; at C5-C6 moderate to severe bilateral neural foraminal narrowing and mild canal stenosis secondary to 2-3 mm posterior disc bulge and uncovertebral osteophyte formation. The official radiology report is not submitted. The last Orthopedic Spine Surgery note is dated 5/21/2014. The note indicates that there was adjacent segment disease at C4-5 and C6-7. Conservative treatment including physical therapy and epidural steroid injections have been tried but details are not reported. The note indicates EMG and nerve conduction study had been performed but again details are not reported. The

recommendation was removal of instrumentation at C5-6 with exploration of the fusion and more extensive fusion at C4-5 and C6-7 with instrumentation from C4-C7. The surgeon also commented that the surgery was likely to make the dysphagia worse. There is no mention of hardware failure as reported by the primary treating physician. A detailed neurologic examination was not performed. However, weakness in the deltoids and biceps as well as triceps was reported at 4/5 bilaterally. In light of the absence of any recent documentation of objective neurologic deficit, absence of documentation of any recent non-operative treatment, and absence of any recent electrophysiologic evidence of radiculopathy at the level above and below the fusion, the request for extension of the fusion from C4-C7 (C4-5 and C6-7 with hardware removal at C5-6) is not supported by guidelines and as such, the medical necessity of the request is not substantiated. The above surgical request is taken from the RFA dated 11/20/2014 and the Orthopedic Spine Consultation of 5/21/2014 although the IMR application mentions a request for fusion at C4-5 and C5-6 with hardware removal at C5-6. There is already a solid fusion at C5-6 and so the request as stated is not correct. However, the same decision applies to the request as stated on the IMR application for the aforementioned reasons.