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| Case Number: | CM15-0223473 | | |
| Date Assigned: | 11/19/2015 | Date of Injury: | 09/26/1977 |
| Decision Date: | 12/30/2015 | UR Denial Date: | 10/12/2015 |
| Priority: | Standard | Application Received: | 11/13/2015 |

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 60 year old male, who sustained an industrial injury on 9-26-1977. The injured worker was being treated for status post anterior cervical. This injured worker is a 60-year-old male who sustained an industrial injury on 9/26/77. Injury was reported relative to cumulative trauma as a police officer. He underwent anterior cervical discectomy and fusion at C4/5 and C5/6 with plate and allograft on 10/9/08. Conservative treatment had included pain and anti-inflammatory medications and activity modification. The 9/9/15 cervical spine MRI impression documented evidence of previous spinal surgery with metal screws through the C4 through C6 vertebral bodies and evidence of prior disc surgery at the C4/5 and C5/6 disc spaces. There was a 4 mm left paracentral disc protrusion compressing the thecal sac and narrowing the lateral recess with compression on the left C7 nerve root and minimally indenting the left ventral aspect of the cervical cord. There was a component of congenital spinal stenosis that made the disc protrusion at the C6/7 disc space even more significant. There was a central 2 mm disc protrusion at C5/6 remaining that minimally indented the ventral thecal sac without compression of the cervical cord or associated nerve roots. The 9/22/15 treating physician report indicated the injured worker was seen in follow-up for MRI review. Physical exam documented posterior cervical muscle tenderness, decreased range of motion, and diminished left C7 dermatomal sensation. Upper extremity strength and reflexes were within normal limits. Imaging showed large left paracentral disc protrusion compressing the cord and narrowing the left lateral recess with compression on the left C7 nerve root. There was adequate decompression across C4/5 and small posterior bone overgrowth at C5/6. The injured worker had a significant change in his

symptoms. His neck and arm pain were quite disabling again. There is a large herniation taking out his cord junctional below the prior fusion. There was also concern regarding the healing of the grafts. Authorization was requested for an anterior cervical discectomy and fusion (ACDF) at C6/7 with removal of old hardware C4-6 and possible graft of C4/5 and C5/6, and 1 day inpatient hospital stay. The 10/12/15 utilization review non-certified the ACDF at C6/7 with removal of old hardware C4-6 and possible graft of C4/5 and C5/6, and 1 day inpatient hospital stay as there were minimal objective findings correlated with imaging evidence of a disc protrusion at C6/7, and no evidence of an appropriate course of conservative treatment. The 11/2/15 treating physician report indicated that the injured worker was status post anterior cervical discectomy and fusion at C4/5 and C5/6 with delayed union at C4/5 and C6/7 and acute junctional herniation at C6/7. Authorization was requested for removal of the plate at C4/5 and C5/6, inspection of the fusions C4/5 and C5/6 with re-graft if necessary, and removal of the extrusion at C6/7 with cage, graft, and plating.

IMR ISSUES, DECISIONS AND RATIONALES

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

ACDF C6-7; remove old hardware C4-6; possible graft of C4-5, C5-6: Overturned

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines, 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. Guidelines state that pseudoarthrosis is recognized as an etiology of continued cervical pain and unsatisfactory outcome. Treatment options include a revision anterior approach vs. a posterior approach. Regardless of approach, there is a high rate of continued moderate to severe pain even after solid fusion is achieved. Guideline criteria have been met. This injured worker presents with worsening neck and arm pain. Significant functional limitation was documented. Clinical exam findings are consistent with imaging evidence of left C7 nerve root compromise. There is also evidence of delayed union at the C4/5 and C5/6 level relative to the 2008 fusion. Evidence of long-term reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. Therefore, this request is medically necessary.

1 Day 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 and Upper Back (Acute & Chronic) Hospital length of stay.

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 hospital length of stay recommendations. The Official Disability Guidelines recommend the median length of stay (LOS) based on type of surgery, or best practice target LOS for cases with no complications. The recommended median and best practice target for anterior cervical fusion and decompression is 1-2 days. This request is consistent with guideline recommendations. Therefore, this request is medically necessary.