

Case Number:	CM15-0042882		
Date Assigned:	03/13/2015	Date of Injury:	09/30/2008
Decision Date:	05/12/2015	UR Denial Date:	02/03/2015
Priority:	Standard	Application Received:	03/06/2015

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 46 year old female, who sustained a work/ industrial injury on 9/30/08. She has reported initial symptoms of neck pain that radiated down into the right hand. The injured worker was diagnosed as having cervical myelopathy secondary to spinal cord compression at C3-4, C4-5, C5-6. Treatments to date included conservative measures, diagnostics, and medication. Magnetic Resonance Imaging (MRI) study on 10/9/14 of the cervical spine demonstrated 2mm disc herniations causing compression of the spinal cord at C3-4, C4-5, and C5-6. Electromyogram/nerve conduction velocity (EMG/NCV) was unremarkable. The injured worker complained of excruciating neck pain that radiated into the right hand with progressive weakness and numbness sensation. The treating physician's report (PR-2) from 2/10/15 indicated per exam that the motor strength was 3/5 in the right finger flexors and intrinsic muscles of the right hand. The right foot dorsiflexors, plantar flexors, and hamstring muscles were also 4/5. Sensory exam noted loss to light touch, pinprick, and two point discrimination in the right first, fourth, and fifth fingers. Deep tendon reflexes were symmetric. The injured worker limped on the right leg. There was a positive Spurling test. When tapping the vertex of the head, the injured worker experienced neck pain. Lateral rotation of her head either to the left or the right side caused dizziness and tingling sensation especially in the right arm. Extension of the neck caused pain, headaches, and pain in both eyes and lightheadedness. There was a positive Tinel's sign. Medications included OxyContin, Lyrica, Multivitamin, and Soma. Treatment plan included anterior cervical discectomy & fusion at C3-4, C4-5 and C5-6. Utilization Review certified the request at C5-6 but noncertified C3-4 and C4-5. The injured

worker underwent surgery on 3/3/2015. At the time of surgery there was instability and a bone spur noted at C4-5 and so 2 level fusion was performed at C4-5 and C5-6. The IMR pertains to the original request for a 3 level fusion which was modified by UR.

IMR ISSUES, DECISIONS AND RATIONALES

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

Anterior cervical discectomy & fusion at C3-4 and C4-5: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

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

Decision rationale: California MTUS guidelines indicate 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. Surgical referral is indicated in the presence of severe and disabling shoulder or arm symptoms, activity limitation for more than one month or with extreme progression of symptoms, 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 examination dated February 10, 2015 revealed severe and debilitating neck pain that radiated into the right hand and was associated with progressive weakness and numbness of the right hand. The report indicates that surgery was authorized at the C5-6 level. On 10/9/2014 a new MRI of the cervical spine demonstrated disc herniations measuring 2 mm causing compression of the spinal cord at C3-4, C4-5, and C5-6. The operative report dated 3/3/2015 indicated cervical radiculopathy secondary to disc herniations at C4-5 and C5-6. There was also instability documented at C4-5. The procedure consisted of anterior cervical discectomy and bilateral foraminotomy at C4-5 and C5-6 using the operative microscope. Arthrodesis at C4-5 and C5-6 was performed using autograft. Review of the utilization review decision of 2/3/15 indicates that surgery was certified at C5-6. The documentation also indicates that C4-5 level had been certified in the past but surgery could not be performed because of the unforeseen deaths of her parents and brother. However, the herniation had shrunk on the new MRI and therefore this level was not certified. Based upon the operative findings including documentation of instability intraoperatively at C4-5 and the presence of a prominent osteophyte arising from the lower body of C4 that was causing compression of the spinal cord, the anterior cervical discectomy and fusion at C4-5 and C5-6 was appropriate and medically necessary. Although the MRI of 10/9/2014 revealed a 2 mm central disc protrusion at C3-4 contacting the ventral cord surface, the neural foramina were patent and the spinal canal was only mildly narrowed. There is no documented instability at C3-4. There is also no evidence of radiculopathy at that level documented with electrophysiologic studies. As such, although the requests for anterior cervical discectomy and fusion at C4-5 and C5-6 are supported, and the surgery was performed on 3/3/2015 at these levels, the additional request for C3-4 anterior

cervical discectomy and fusion is not supported and the medical necessity of the request has not been substantiated. The request is not medically necessary.