

Case Number:	CM15-0048590		
Date Assigned:	03/20/2015	Date of Injury:	04/09/2006
Decision Date:	05/06/2015	UR Denial Date:	03/06/2015
Priority:	Standard	Application Received:	03/13/2015

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:

This injured worker is a 57-year-old male sustained an industrial injury on 4/9/06. Injury occurred when he tripped and fell backward on a customer's cart with a workbench falling against his chest. Past surgical history was positive for lumbar laminectomy in 200 and anterior and posterior lumbar fusion in 2001. He subsequently underwent C3/4, C4/5, and C5/6 anterior cervical discectomy and fusion on 3/25/11. The 9/22/14 cervical spine MRI impression documented interval development of moderate diffuse disc bulge versus a broad-based central to left paracentral disc protrusion at C6/7, encroaching into the left neural foramen and causing possible mass effect on the left C7 nerve root. There was interval anterior cervical discectomy and fusion from C3-C6/7 with some residual neuroforaminal stenosis, most significantly at C5/6 on the right, and no residual central canal stenosis. There was no other focal disc herniation or acute disease process seen. Findings at C2/3 documented a mild anterior disc bulge with no significant posterior bulge or herniation. The central canal and neural foramen were patent. He underwent cervical C7/T1 epidural steroid injection on 11/3/14 with greater than 50% relief for one week. The 12/17/14 neurosurgical report cited grade 6-9/10 cervical pain radiating to both arms, and associated with headaches. The injured worker had good improvement following surgery in 2011 with onset of significant recurrent neck and arm symptoms 9-10 months ago. Imaging showed adjacent segment protrusion broad-based bulge at C6/7. Pain radiating into the right elbow and left fingers with numbness and tingling. There were significant occipital cervical tension headaches. Physical exam documented spasms, guarding, and loss of lordosis. There was mild loss of cervical motion, and positive Spurling's sign. Deep tendon reflexes were 2-3+

biceps, 2+ triceps, and 1-2+ brachioradialis. There was 4/5 motor weakness to the deltoid, triceps, and intrinsic, left greater than right. There was left greater than right sensory loss over the radial forearm, thumb, and index, middle and small fingers. The assessment was status post C3/4, C4/5, and C6/7 discectomy, C2 adjacent segment bulge with cervical tension headaches, C6/7 adjacent segment disc protrusion with radiculopathy, and possible C7/T1 anterolisthesis. The treatment plan requested authorization for cervical spine films, including flexion/extension views, to determine degree of anterolisthesis or instability. EMG and NCV to determine persistent nerve root irritation at C4, C5, and C6 from persistent foraminal stenosis. The 3/2/15 electrodiagnostic study evidenced left C5 through C8, and right C8 radiculopathy. Recent conservative treatment had included medications, and C7/T1 cervical epidural steroid injection. The 3/6/15 utilization review non-certified the request for C3-C7 laminoplasty and fusion based on no evidence of stenosis or EMG evidence of radiculopathy to confirm the medical necessity of C3/4 being incorporated into the fusion mass. Criteria had been met for inclusion of C4 to C8. In the documented peer-to-peer discussion, the treating physician felt the C3/4 level had been under read in the imaging study and there was significant stenosis in the sagittal plane.

IMR ISSUES, DECISIONS AND RATIONALES

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

C3-7 Laminoplasty with 1 Day Inpatient Length of Hospital Stay: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

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; Hospital length of stay (LOS).

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) provides specific criteria for cervical laminoplasty. 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 not been met. This injured worker presents with neck pain radiculitis to both arms with associated headaches. Clinical exam findings are consistent with imaging evidence of nerve root compression at C7 and electrodiagnostic evidence of C5-8 radiculopathy. There is no imaging evidence of significant adjacent segment disease or nerve root compression at C3/4 to support the medical necessity of surgical intervention at that level. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. Therefore, this request is not medically necessary.