

Case Number:	CM15-0057087		
Date Assigned:	04/01/2015	Date of Injury:	05/24/2000
Decision Date:	05/05/2015	UR Denial Date:	03/18/2015
Priority:	Standard	Application Received:	03/25/2015

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 67-year-old female with an industrial injury dated 5/24/00. Injury occurred when she slipped and fell. She had a long course of chiropractic treatment, medication management, activity modification, and epidural steroid injections. The 9/2/14 cervical spine MRI impression documented moderate diffuse disc bulge at C6/7 with effacement of the thecal sac and narrowing of the AP diameter of the central canal to 8.5 mm, and mild left foraminal encroachment. The 1/15/15 treating physician report cited severe neck and left arm pain, numbness and weakness. Neck pain radiated into the left parascapular region and down to the ulnar aspect of the forearm, with tingling of the ulnar aspect left hand. Pain relief was noted with heat, immobilization and pain pills. She had a history of transient ischemic attacks. She had questionable loss of balance. Physical exam documented cervical flexion and extension 45 degrees, rotation 75 degrees right and 60 degrees left. Grip strength was 20 pounds left, 40 pounds right. Sensation was decreased over the left C7 and C8 dermatomes. Upper extremity deep tendon reflexes were 2+ and symmetrical, patellar reflexes 3+, and Achilles reflexes 2+. There was no ankle clonus. Hoffman's and Lhermitte's tests were negative. Upper extremity motor strength was 5/5. An EMG was requested. The 1/15/15 x-rays showed degenerative changes, predominantly at the C6/7 level. The 2/3/15 electrodiagnostic study showed evidence of a probable mild left C7 radiculitis involving the posterior primary ramus. There was no evidence of left cervical radiculopathy. The 3/5/15 treating physician report cited neck pain equally severe to her left upper extremity numbness, tingling and weakness. She had left parascapular muscle spasms with radiation of pain to her triceps and the ulnar aspect of her forearm, with tingling of

the left ring and little finger. She dropped things frequently. Physical exam documented decreased sensation at the left C7 and C8 dermatomes and positive Spurling test. Hoffman's test was negative. Lhermitte's test was normal. MRI findings showed severe C6/7 degenerative spondylosis with severe left foraminal stenosis. Conservative treatment had been exhausted. Authorization was requested for two-day inpatient surgery: anterior cervical C6-C7 discectomy, fusion using left iliac crest bone graft and anterior instrumentation with locking plate. The 3/18/15 utilization review non-certified the request for C6/7 anterior cervical discectomy and fusion with 2-day hospital stay noting a history of depression and bipolar disorder, and indicating that this should be an outpatient procedure.

IMR ISSUES, DECISIONS AND RATIONALES

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

2 day inpatient surgery: anterior cervical C6-C7 discectomy, fusion using left iliac crest bone graft and anterior instrumentation with locking plate: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 180, 183. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) (20th annual edition) & ODG Treatment in Workers' Comp (13th annual edition), 2015 Neck & Upper Back Chapter.

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, 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. The ODG recommend a one-day stay for anterior cervical fusion and outpatient status for cervical discectomy. Guideline criteria have not been met. This patient presents with persistent and function-limiting neck pain and left upper extremity symptoms. Clinical exam findings are consistent with imaging and electrophysiologic evidence of C7 nerve root compromise. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. However, records suggest a significant psychological history with no evidence of psychological screening. Additionally, guidelines do not support a 2-day admission and there is no compelling rationale presented to exceed guideline recommendations. Therefore, this request is not medically necessary at this time.