

Case Number:	CM15-0081576		
Date Assigned:	05/04/2015	Date of Injury:	09/09/2012
Decision Date:	06/02/2015	UR Denial Date:	04/02/2015
Priority:	Standard	Application Received:	04/28/2015

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 36-year-old male who sustained an industrial injury on 9/9/12. The mechanism of injury was not documented. The injured worker underwent C5/6 anterior cervical discectomy and fusion in 2013. The 4/6/14 left shoulder MRI demonstrated supraspinatus tendinosis with partial tear near its insertion and minimal subacromial and subscapularis bursitis. The 4/7/14 cervical spine MRI documented C5/6 was surgically fused with an anterior fixation device spanning the C5 and C6 vertebrae. There was a diffuse disc protrusion at C5/6 effacing the thecal sac, and bilateral neuroforaminal narrowing effacing the left and right C6 exiting nerve roots, worse on the left. At C3/4, there was diffuse disc protrusion effacing the thecal sac and narrowing the right neural foramen with effacement of the right C4 exiting nerve root. There was a focal central disc protrusion at C4/5 effacing the thecal sac and narrowing the right neural foramen with effacement of the right C5 exiting nerve root. AT C6/7, there was a broad-based disc protrusion effacing the thecal sac and spinal cord. There was bilateral neuroforaminal stenosis that effaced the right and encroached the left C7 exiting nerve roots. The injured worker underwent a C6/7 cervical epidural steroid injection on 12/3/14. The 1/7/15 cervical CT scan conclusion documented status post anterior fusion C5/6 with bone graft material in place and non-specific straightening of the normal cervical lordosis most likely secondary to fusion. There was residual osteophytic ridge at C5/6 that resulted in bilateral neuroforaminal narrowing. The 1/7/15 cervical spine x-ray findings documented anterior fusion C5/6, non-specific straightening of the normal cervical lordosis most likely secondary to fusion, and otherwise unremarkable study. The 3/6/15 pain management report cited chronic grade 8-9/10 cervical and lumbar spine

pain. He reported no improvement following a cervical epidural steroid injection on 12/3/14. He reported some improvement with trigger point injections for several days. He reported an acute flare-up of left mid-trapezius muscle pain. Cervical spine exam documented cervical paravertebral muscle tenderness and multiple trigger points in the left upper back. Dysesthesias were noted in the C6 and C7 dermatomal distributions bilaterally. The diagnosis included chronic post-operative pain of the cervical spine and cervical radiculopathy. Trigger point injections were performed in the left upper back. The 3/24/15 orthopaedic surgery report cited cervical paraspinal tenderness to palpation. Physical exam documented normal cervical range of motion, left shoulder flexion/abduction 120 degrees, 4/5 shoulder abduction strength, decreased left C6 dermatomal sensation, intact upper extremity deep tendon reflexes, and positive Neer's sign on the left. The CT scan showed C5 to C6 arthrosis. The assessment was pseudoarthrosis of the cervical fusion and left shoulder impingement syndrome with a component of adhesive capsulitis. The treatment plan requested appeal of prior denial for shoulder diagnostic arthroscopy with subacromial decompression and possible lysis of adhesions, and authorization for a C5 to C6 revision fusion. The 4/2/15 utilization review non-certified the request for C5/6 revision fusion as there were multiple potential pain generators, significant psychological issues that had not been adequately addressed, no documentation of persistent or progressive radicular pain attributed to the C5/6 level, no documentation of spinal instability, and no documentation of tobacco use/abstinence.

IMR ISSUES, DECISIONS AND RATIONALES

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

C5-C6 fusion revision: 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), Neck and Upper Back Chapter, Fusion.

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: Fusion, anterior cervical.

Decision rationale: The California Medical Treatment Utilization Schedule guidelines provide a general recommendation for fusion surgery, including consideration of pre-surgical psychological screening. The Official Disability Guidelines (ODG) 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 not been fully met. This patient presents with persistent cervical pain 2 years status post anterior cervical discectomy and fusion at C5/6. The 4/16/14 cervical MRI, 1/7/15 cervical CT scan, and 1/7/15 cervical spine x-rays do not evidence a pseudoarthrosis at C5/6. There is multilevel cervical disc disease and potential nerve root compromise documented on imaging with no clear evidence of pain generation limited to the C5/6 level. Additionally, there is no documentation of the patient's current smoking status or discussion of potential psychological issues. Therefore, this request is not medically necessary at this time.

