

<b>Case Number:</b>	CM15-0082475		
<b>Date Assigned:</b>	05/04/2015	<b>Date of Injury:</b>	07/27/2010
<b>Decision Date:</b>	06/03/2015	<b>UR Denial Date:</b>	04/22/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/29/2015

### 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: Iowa, Illinois, Hawaii

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & General Preventive Medicine

### 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 57 year old female, who sustained an industrial injury on 07/27/2010. She reported neck and low back injuries. The injured worker is currently diagnosed as having pseudoarthritis of cervical spine, thoracic or lumbar radiculitis, and status post cervical spinal fusion. Treatment and diagnostics to date has included cervical spine MRI, cervical disectomy and fusion, physical therapy, and medications. In a progress note dated 03/09/2015, the injured worker presented with complaints of severe pain in her neck 12 weeks status post cervical spine fusion. The treating physician reported requesting authorization for retroactive cervical spine fusion.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retro cervical spine fusion:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 188 see Table -8-8. Decision based on Non-MTUS Citation Official

Disability Guidelines (ODG) Neck and Upper Back, (Acute & Chronic), Fusion, anterior cervical.

**Decision rationale:** ACOEM States concerning cervical fusion "Indications clear for failed conservative treatment and history, exam, and imaging consistent for specific lesion." This is a ACOEMD recommendation. ACOEMD recommendation, Panel interpretation of information not meeting inclusion criteria for research-based evidence. ODG Criteria for Cervical Fusion Recommended Indications: (1) Acute traumatic spinal injury (fracture or dislocation) resulting in cervical spinal instability. (2) Osteomyelitis (bone infection) resulting in vertebral body destruction. (3) Primary or metastatic bone tumor resulting in fracture instability or spinal cord compression. (4) Cervical nerve root compression verified by diagnostic imaging (i.e., MRI or CT myelogram) and resulting in severe pain OR profound weakness of the extremities. (5) Spondylotic myelopathy based on clinical signs and/or symptoms (Clumsiness of hands, urinary urgency, new-onset bowel or bladder incontinence, frequent falls, hyperreflexia, Hoffmann sign, increased tone or spasticity, loss of thenar or hypothenar eminence, gait abnormality or pathologic Babinski sign) and Diagnostic imaging (i.e., MRI or CT myelogram) demonstrating spinal cord compression. (6) Spondylotic radiculopathy or nontraumatic instability with All of the following criteria: (a) Significant symptoms that correlate with physical exam findings AND radiologist-interpreted imaging reports. (b) Persistent or progressive radicular pain or weakness secondary to nerve root compression or moderate to severe neck pain, despite 8 weeks conservative therapy with at least 2 of the following: Active pain management with pharmacotherapy that addresses neuropathic pain and other pain sources (e.g., an NSAID, muscle relaxant or tricyclic antidepressant); Medical management with oral steroids, facet or epidural injections; Physical therapy, documented participation in a formal, active physical therapy program as directed by a physiatrist or physical therapist, may include a home exercise program and activity modification, as appropriate. (c) Clinically significant function limitation, resulting in inability or significantly decreased ability to perform normal, daily activities of work or at-home duties. (d) Diagnostic imaging (i.e., MRI or CT myelogram) demonstrates cervical nerve root compression, or Diagnostic imaging by x-ray demonstrates Instability by flexion and extension x-rays; Sagittal plane translation >3mm; OR Sagittal plane translation >20% of vertebral body width; OR Relative sagittal plane angulation >11 degrees. (e) Not recommend repeat surgery at the same level. (f) Tobacco cessation: Because of the high risk of pseudoarthrosis, a smoker anticipating a spinal fusion should adhere to a tobacco- cessation program that results in abstinence from tobacco for at least six weeks prior to surgery. (g) Number of levels: When requesting authorization for cervical fusion of multiple levels, each level is subject to the criteria above. Fewer levels are preferred to limit strain on the infused segments. If there is multi-level degeneration, prefer limiting to no more than three levels. With one level, there is approximately a 80% chance of benefit, for a two-level fusion it drops to around 60%, and for a three-level fusion to around 50%. But not fusing additional levels meeting the criteria, risks having to do future operations. (h) The decision on technique (e.g., autograft versus allograft, instrumentation) should be left to the surgeon. The medical documentation provided do not indicate signs of radiculopathy, no findings of instability, the patient's report of pain was inconsistent with the MRI results that were provided and the EMG submitted was within normal limits. The treating physician has not met the above guidelines at this time. As such, the request for Retro cervical spine fusion is not medically necessary.