

Case Number:	CM15-0083312		
Date Assigned:	05/05/2015	Date of Injury:	11/08/2000
Decision Date:	06/08/2015	UR Denial Date:	04/02/2015
Priority:	Standard	Application Received:	04/30/2015

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 70-year-old female who sustained an industrial injury on 11/08/00. The mechanism of injury was not documented. Past surgical history was positive for anterior cervical fusion C5-7. The 2/5/15 cervical spine CT scan findings documented a 1-2 mm broad-based posterior disc protrusion at C4/5, resulting in bilateral neuroforaminal narrowing in conjunction with uncovertebral osteophyte formation and bilateral exiting nerve root compromise. The patient was status post anterior fusion C5-7 in anatomic alignment with bone graft material seen at C5/6 and C6/7. The 2/14/15 cervical spine MRI impression documented 1-2 mm broad-based posterior disc protrusions at C3/4, C4/5, and C6/7 resulting in bilateral neuroforaminal narrowing in conjunction with uncovertebral osteophyte formation. There was bilateral exiting nerve root compression seen at each of these levels. At C5/6 and C6/7, fusion was noted without evidence of canal stenosis or neuroforaminal narrowing. The 3/24/15 treating physician report indicated that the patient had no improvement in her symptoms. Physical exam documented cervical paraspinal tenderness to palpation, mild loss of left cervical rotation, normal upper extremity motor function, 2+ and symmetrical upper extremity deep tendon reflexes, and diminished sensation over the bilateral C5 dermatomes. The diagnosis was cervical radiculitis and aberrant hardware. The treatment plan recommended removal of hardware C5-7 and C4/5 anterior cervical discectomy and fusion, and post-operative physical therapy 2x8. The 4/2/15 utilization review non-certified the request for C4/5 anterior cervical discectomy and fusion, C5-7 removal of hardware, and associated physical therapy, as MRI findings did not correlate with the injured worker's symptoms and there was no documentation of psychological

clearance, and guidelines did not recommend hardware implant removal except in cases of broken hardware or persistent pain. The treating physician appealed the denial for anterior cervical discectomy and fusion as there was distinct diminished sensation over the C5 dermatome, consistent with MRI findings of C4 to C5 disc herniation.

IMR ISSUES, DECISIONS AND RATIONALES

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

C4-5 Anterior cervical discectomy and fusion, C5-7 removal of hardware: 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, Low Back (updated 03/24/2015) - online version.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 179-181. Decision based on Non-MTUS Citation The California Medical Treatment Utilization Schedule.

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) provides 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 Official Disability Guidelines generally do not recommend removal of hardware implanted for fixation, except in the care of broken hardware or persistent pain, after ruling out other causes of pain such as infection and non-union. Guideline criteria have not been met. This patient presents with persistent neck and arm pain, and sensory loss in the bilateral C5 dermatomal pattern. There is no clinical exam evidence of motor deficit, reflex changes or positive EMG findings that correlate with the involved cervical levels. There is imaging evidence of bilateral nerve root compression at the C3/4, C4/5, and C6/7 levels. Detailed evidence of a recent reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. There is no discussion of a psychosocial screen. There is no rationale presented for the removal of hardware from C5-C7 relative to loosening, persistent localized pain, or infection. Therefore, this request is not medically necessary.

Post-op physical therapy 2x8 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Postsurgical Treatment Guidelines Page(s): 26.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 26.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.