

Case Number:	CM15-0087692		
Date Assigned:	05/11/2015	Date of Injury:	06/08/1999
Decision Date:	06/18/2015	UR Denial Date:	04/15/2015
Priority:	Standard	Application Received:	05/07/2015

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: California
Certification(s)/Specialty: Internal 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 54-year-old male, who sustained an industrial injury on 06/08/1999. On provider visit dated 04/02/2015 the injured worker has reported cervical spine complaints. On examination of the cervical spine, he was noted to have a decreased range of motion and posterior tenderness. There was a well-healed anterior transverse incision noted. Straight-line gait was noted as unsteady. Spurling's sign was positive bilaterally. The diagnoses have included status post anterior cervical discectomy and fusion at C4 to C7 in 2002, postoperative dysphagia, adjacent segment breakdown with myelopathy and likely pseudarthrosis. Treatment to date has included physical therapy, injections and medication. The injured worker is noted not to be working. The provider requested CT cervical spine without contrast to assess for healing of previous fusion, and MRI of cervical spine without contrast to look for nerve compression.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 CT cervical spine without contrast: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back (Acute & Chronic).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179, 181-183.

Decision rationale: Medical Treatment Utilization Schedule (MTUS) addresses cervical spine MRI magnetic resonance imaging. American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 8 Neck and Upper Back Complaints indicates that MRI or CT is recommended to evaluate red-flag diagnoses. MRI or CT is recommended when red flags for fracture, or neurologic deficit associated with acute trauma, tumor, or infection are present. MRI or CT to validate diagnosis of nerve root compromise, based on clear history and physical examination findings, in preparation for invasive procedure is recommended. Criteria for ordering imaging studies include emergence of a red flag and physiologic evidence of tissue insult or neurologic dysfunction. Physiologic evidence may be in the form of definitive neurologic findings on physical examination, electro diagnostic studies, laboratory tests, or bone scans. Unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies if symptoms persist. An imaging study may be appropriate for a patient whose limitations due to consistent symptoms have persisted for four to six weeks or more to further evaluate the possibility of potentially serious pathology. The neurosurgical spinal surgery report dated January 13, 2015 documented magnetic resonance imaging MRI performed in November 2014 revealed severe stenosis from a 4 mm ridge at C3-C4 and a dorsal impingement from ligamentous facet hypertrophy adjacent to the C4-C7 fusion. The MRI shows C7-T1 bulge. C3-C4-C5 posterior cervical laminoplasty was recommended. The orthopedic consultation report dated 04/02/2015 documented that the patient underwent an anterior cervical discectomy and fusion at C4 to 7 in 2002. This was done predominantly for neck and arm pain symptoms. The neck and arm pain did not really improve much either in the immediate postsurgical or at several months after his surgery. His postoperative course was challenging, notable for pain, and subsequent to the surgery, he has had very severe issues with swallowing. This has been very severe. There is an area of focal narrowing anterior to the cervical instrumentation at approximately the C5 level. The degree of dysphagia is quite severe. Dysphagia is typical after this type of surgery but his degree of dysphagia, which includes liquids as well as solid food, is beyond what would be typical. He also has significant pain issues. Currently he has pain in the neck with associated cervicogenic headaches, radiation into the trapezius and periscapular area bilaterally with extension of these symptoms down the arm with associated numbness and paresthesias in a multidermatomal distribution. The patient's pain is worse with attempted neck motion, better with rest. Currently he is extremely limited, unable to work and unable to perform most routine activities of daily living. Prior treatments have been extensive including physical therapy, multiple forms of medical pain management and multiple forms of injection based pain management. He is right-hand dominant. He has progressive dysfunction in the fine motor skills of his hands and decreasing balance. Open MRI was available for review accompanied by radiographs. These demonstrate adjacent segment breakdown with cervical myelopathy at the C3-4 level. The instrumentation appears to be in good position. The current imaging is very suggestive of the presence of pseudarthrosis at the C6-7 level. The assessment was postoperative dysphagia, adjacent segment breakdown with myelopathy and likely pseudarthrosis. The patient's situation is challenging. The severity of his dysphagia is very concerning. He has objective pain generators in his neck that could contribute to his symptomatology including

adjacent segment breakdown with evidence of myelopathy as well as potential pseudarthrosis. To further delineate these issues, the recommendation is to obtain a better quality MRI study to look for residual nerve compression. The formatting of the previous study limits the evaluation of any potential areas of compression behind the previous fusion. Additionally the quality of the imaging is poor as it was an open MRI. Patient requires a CT of his cervical spine to assess for healing of the previous fusion as this relates to decision making regarding pseudarthrosis. Per ACOEM, computed tomography CT in preparation for invasive procedure is recommended. The neurosurgical spinal surgery report dated January 13, 2015 documented that C3-C4-C5 posterior cervical laminoplasty was recommended. The orthopedic consultation report dated 04/02/2015 documented that the patient requires a CT of the cervical spine to assess for healing of the previous fusion as this relates to decision making regarding pseudarthrosis. MTUS, ACOEM, and the medical records support the request for computed tomography CT of the cervical spine. Therefore, the request for computed tomography CT of the cervical spine is medically necessary.

1 MRI of cervical spine without contrast: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back (Acute & Chronic).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179, 181-183.

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surgery, he has had very severe issues with swallowing. This has been very severe. There is an area of focal narrowing anterior to the cervical instrumentation at approximately the C5 level. The degree of dysphagia is quite severe. Dysphagia is typical after this type of surgery but his degree of dysphagia, which includes liquids as well as solid food, is beyond what would be typical. He also has significant pain issues. Currently he has pain in the neck with associated cervicogenic headaches, radiation into the trapezius and periscapular area bilaterally with extension of these symptoms down the arm with associated numbness and paresthesias in a multidermatomal distribution. The patient's pain is worse with attempted neck motion, better with rest. Currently he is extremely limited, unable to work and unable to perform most routine activities of daily living. Prior treatments have been extensive including physical therapy, multiple forms of medical pain management and multiple forms of injection based pain management. He is right-hand dominant. He has progressive dysfunction in the fine motor skills of his hands and decreasing balance. Open MRI was available for review accompanied by radiographs. These demonstrate adjacent segment breakdown with cervical myelopathy at the C3-4 level. The instrumentation appears to be in good position. The current imaging is very suggestive of the presence of pseudarthrosis at the C6-7 level. The assessment was postoperative dysphagia, adjacent segment breakdown with myelopathy and likely pseudarthrosis. The patient's situation is challenging. The severity of his dysphagia is very concerning. He has objective pain generators in his neck that could contribute to his symptomatology including adjacent segment breakdown with evidence of myelopathy as well as potential pseudarthrosis. To further delineate these issues, the recommendation is to obtain a better quality MRI study to look for residual nerve compression. The formatting of the previous study limits the evaluation of any potential areas of compression behind the previous fusion. The quality of the imaging is poor as it was an open MRI. Per ACOEM, MRI in preparation for invasive procedure is recommended. The neurosurgical spinal surgery report dated January 13, 2015 documented that C3-C4-C5 posterior cervical laminoplasty was recommended. The orthopedic consultation report dated 04/02/2015 documented the recommendation to obtain a better quality MRI study to look for residual nerve compression. The formatting of the previous study limits the evaluation of any potential areas of compression behind the previous fusion. The quality of the imaging is poor as it was an open MRI. MTUS, ACOEM, and the medical records support the request for magnetic resonance imaging MRI of the cervical spine. Therefore, the request for magnetic resonance imaging MRI of the cervical spine is medically necessary.