

Case Number:	CM15-0088731		
Date Assigned:	05/12/2015	Date of Injury:	07/26/1998
Decision Date:	06/12/2015	UR Denial Date:	05/08/2015
Priority:	Standard	Application Received:	05/08/2015

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 male who sustained an industrial injury on 7/26/98. The mechanism of injury was not documented. Past surgical history was positive anterior cervical discectomy and fusion with retained hardware at C5/6. Conservative treatment included medications, activity modification, physical therapy, and acupuncture. The 1/30/15 cervical spine MRI impression documented 3-4 mm C6/7 diffuse bulging of the annulus with osteophytic ridging that moderately narrows the right neural foramen. There was no significant left foraminal stenosis. A 2 mm central disc bulge mildly narrowed the canal effacing but did not compress the cord. There was 1-2 mm anterolisthesis of C4 on C5 with a 1 mm central disc bulge resulting in minimal canal narrowing without cord compression. There was a left sided disc bulge extending into the left neural foramen with moderately severe left facet hypertrophy which moderate to severely narrowed the left neural foramen which could affect the exiting left C5 nerve root. At C5/6, there was solid anterior interbody fusion without canal or foraminal stenosis. Anterior plate and vertebral body screws were in good position. Findings documented evidence of solid osseous fusion, no residual canal or foraminal stenosis, and mild to moderate left facet arthropathy. At C2/3, there was diffuse disc bulge with facet hypertrophy. At C3/4, there was mild to moderate foraminal stenosis from facet arthropathy and slight disc bulge with anterolisthesis. The 3/10/15 electrodiagnostic study was reported as normal. The 4/2/15 treating physician report indicated the injured worker was highly symptomatic with neck and right arm complaints. Cervical exam documented mild loss of cervical range of motion. Neurologic exam documented 4+/5 right deltoid weakness, diminished right upper extremity sensation, and +1 and

symmetrical upper extremity deep tendon reflexes. There was right trapezius muscle tenderness. Grip strength was decreased on the right. Recent electrodiagnostic testing was reported normal. The injured worker had been refractory to conservative management. The treating physician report indicated that he did not have a surgical option and recommended a second opinion. The 4/28/15 spine surgeon report cited pain down the right arm with extreme pain in the right shoulder and armpit and complaint of dropping things on the right side. He had previously undergone C5/6 anterior cervical discectomy and fusion in 2007. He had an upper extremity electrodiagnostic on 12/18/12 which showed moderate right C7 and mild left C7 sensory dysfunction and a chronic left C7 and possible C8 radiculopathy. Physical exam documented 4/5 biceps weakness with extension of the right arm. Imaging was reviewed and showed positive fusion at the C5/6 level with posterior compression resulting in moderate to severe spinal stenosis at C6/7 with obvious and significant compression of the dura and exiting nerve roots. The diagnosis was prior cervical fusion at C5/6 with adjacent level stenosis C6/7 posteriorly. Authorization was requested for posterior laminectomy at C6/7, posterior mass screws at C6/7, and fusion posterior C6/7. The 5/4/15 request for authorization included posterior laminectomy C5 and C6/7 with instrumentation and fusion. The 5/8/15 utilization review non-certified the request for posterior laminectomy of C5-C6 with instrumentation and fusion as there was no documented evidence of failed conservative therapy directed at the cervical spine and no evidence of spinal instability to justify a posterior cervical fusion.

IMR ISSUES, DECISIONS AND RATIONALES

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

Posterior laminectomy at C5-6 with instrumentation and fusion: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 180-181. Decision based on Non-MTUS Citation Official Disability Guidelines.

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, posterior 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 criteria for cervical discectomy. 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. Guidelines state that posterior cervical fusion is under study. A posterior fusion and stabilization procedure is often used to treat cervical instability secondary to traumatic injury, rheumatoid arthritis, ankylosing spondylitis, neoplastic disease, infections, and previous laminectomy, and in cases where there has been insufficient anterior stabilization. Guideline

criteria have not been met. This injured worker presents with significant neck and right arm pain. He is status post anterior cervical discectomy and fusion at C5/6. There is no current electrodiagnostic or imaging evidence consistent with nerve root compromise at the C5/6 level. There is no evidence of hardware failure or spinal segmental instability at the C5/6 level. Evidence of reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. The neurosurgeon recommended surgery at the C6/7 level which is not consistent with this request. Therefore, this request is not medically necessary.