

Case Number:	CM14-0172136		
Date Assigned:	10/23/2014	Date of Injury:	08/30/2014
Decision Date:	11/25/2014	UR Denial Date:	09/15/2014
Priority:	Standard	Application Received:	10/17/2014

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. The expert reviewer is Board Certified in Orthopedic Spine Surgeon and is licensed to practice in Texas. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 51-year-old male who reported an injury on 08/30/2014. The mechanism of injury was a motor vehicle accident. Prior treatments included physical therapy sessions, medications, left shoulder arthroscopy with debridement, and left ulnar nerve decompression or transposition. The injured worker had undergone an EMG study on 05/06/2008 that revealed evidence of left ulnar decompression. The injured worker had undergone an MRI study of the left shoulder dated 04/08/2013 that revealed high grade supraspinatus tear. The injured worker had undergone an MRI of the cervical spine dated 07/21/2014 that revealed degenerative changes, right C4-5 foraminal stenosis. C5-6: severe left stenosis, mild right stenosis. There was severe bilateral C7-T1 stenosis. The injured worker was evaluated on 09/08/2014 and it was documented the injured worker complained of significant neck and upper extremity radicular symptoms and now numbness worsened in his index finger. He was left hand dominant. He described the pain as sharp and jolting pain, as well as cramping to his fingers. His index finger was the most involved with numbness. He complained of neck, left shoulder, and arm pain. The injured worker stated there was still litigation pending from the accident. The review of systems was significant for some bladder issues and also numbness and tingling in the left upper extremity. On physical examination, the injured worker had positive Spurling's on the left with axial extension and rotation reproduced in the left upper extremity issues. The injured worker also described some sensation deficits in the C6 distribution. The injured worker had pain in the shoulder on range of motion. Actively, the injured worker had 45 degrees of forward flexion and abduction. The treatment plan included anterior cervical discectomy and fusion at C5-6 with autograft and allograft bone and neural monitoring. The diagnoses included cervical degenerative disc disease and cervical spondylosis. The Request for Authorization dated

09/09/2014 was for anterior cervical discectomy and fusion at C5-6 with autograft and allograft bone and associated surgical services; preoperative labs.

IMR ISSUES, DECISIONS AND RATIONALES

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

Anterior cervical discectomy & fusion at C5-6, w/ autograft and allograft bone: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back. Discectomy-laminectomy-laminoplasty.

Decision rationale: The request for anterior cervical discectomy & fusion at C5-6 with autograft and allograft bone is not medically necessary. The Official Disability Guidelines (ODG) recommends cervical discectomy Recommended as an option if there is a radiographically demonstrated abnormality to support clinical findings consistent with one of the following: (1) Progression of myelopathy or focal motor deficit; (2) Intractable radicular pain in the presence of documented clinical and radiographic findings; or (3) Presence of spinal instability when performed in conjunction with stabilization. Surgery is not recommended for disc herniation in a patient with non-specific symptoms and no physical signs. In addition, although surgery for spondylosis and radiculopathy may offer some short term benefit, non-operative treatment with PT can provide similar improvement in pain and function at 12-16 months for patients without progressive neurologic deficits or instability. The American Academy of Orthopedic Surgeons has recommended that an anterior approach is appropriate when there is evidence of radiculopathy, and/or when there is evidence of central location and there is any degree of segmental kyphosis. A posterior approach has been suggested by the same group when there is evidence of lateral soft disc herniation's with predominate arm pain and for caudal lesions in large, short-necked individuals. The overall goals of cervical surgery should be decompression, restoration of alignment, and stability. Cervical fusion is recommended as an option in combination with anterior cervical discectomy for approved indications, although current evidence is conflicting about the benefit of fusion in general. Evidence is also conflicting as to whether autograft or allograft is preferable and/or what specific benefits are provided with fixation devices. Many patients have been found to have excellent outcomes while undergoing simple discectomy alone (for one- to two-level procedures), and have also been found to go on to develop spontaneous fusion after an anterior discectomy. Cervical fusion for degenerative disease resulting in axial neck pain and no radiculopathy remains controversial and conservative therapy remains the choice if there is no evidence of instability. The guidelines also states that autograft and allograft bone; Anterior cervical discectomy compared to anterior cervical discectomy with interbody fusion with a bone graft or substitute: Three of the six randomized controlled studies discussed in the 2004 Cochrane review found no difference between the two techniques and/or that fusion was not necessary. The Cochrane review felt there was conflicting evidence of the relative effectiveness of either procedure. Overall it was noted that patients with discectomy only had shorter hospital stays, and shorter length of operation. There was moderate

evidence that pain relief after five to six weeks was higher for the patients who had discectomy with fusion. Return to work was higher early on (five weeks) in the patients with discectomy with fusion, but there was no significant difference at ten weeks. The medical records submitted for review failed to indicate previous conservative treatment modalities and outcome measurements. There was no description of progressive neurologic deterioration, myelopathy, or spinal instability. The documentation submitted failed to indicate evidence of upper extremity radiculopathy. There is no clear cut unequivocal clinical correlation between physical findings and radiological pathology. Furthermore, there is no description of epidural steroid injections. Moreover, the request that was submitted failed to include inpatient stay for 1 night. As such, the request for anterior cervical discectomy and fusion at C5-6, with autograft and allograft bone is not medically necessary.

Associated Surgical Service: Pre-op labs: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back & Lumbar & Thoracic (Acute & Chronic) Preoperative Testing, General.

Decision rationale: According to the Official Disability Guidelines (ODG) recommends preoperative testing, general. Preoperative additional tests are excessively ordered, even for young patients with low surgical risk, with little or no interference in perioperative management. Laboratory tests, besides generating high and unnecessary costs, are not good standardized screening instruments for diseases. The decision to order preoperative tests should be guided by the patient's clinical history, comorbidities, and physical examination findings. Preoperative routine tests are appropriate if patients with abnormal tests will have a preoperative modified approach (i.e., new tests ordered, referral to a specialist or surgery postponement). Testing should generally be done to confirm a clinical impression, and tests should affect the course of treatment. The request submitted failed to indicate the date of the surgery. The noncertification of the requested procedure for anterior cervical discectomy and fusion at C5-6, with autograft and allograft bone preoperative labs is not medically necessary. As such, the request for associated surgical service: preoperative labs is not medically necessary.