Case Number:	CM15-0143100		
Date Assigned:	08/04/2015	**Date of Injury:**	09/05/2012
Decision Date:	10/08/2015	**UR Denial Date:**	06/23/2015
Priority:	Standard	**Application Received:**	07/23/2015

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: 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 66 year old right hand dominant female who sustained an injury on 9-5-12. The initial symptoms and complaints regarding the injury was a result of continual trauma and her symptoms were reported on November 20, 2012. The symptoms included pain in her neck and upper extremities secondary to prolonged sitting and repetitive typing and inputting data into a computer. At the time of an evaluation on December 18, 2012 the IW was diagnosed with bilateral wrist sprain and repetitive syndrome. Initial treatment included physical therapy and a home exercise program. Electrodiagnostic studies were conducted showing bilateral carpal tunnel syndrome, affecting the shoulders and neck. Ergonomic evaluations were also done with modifications made at the work site which included a new chair and keyboard. Work restrictions included limited typing, no lifting, pulling or pushing more than 5 - 10 pounds. A right carpal tunnel release was done on 6-14-13 and a left long trigger finger release on 8-1-13. On 10-4-13 an injection to the left ring wrist was administered. On 4-29-14 the IW was diagnosed with Cervicalgia, Bilateral shoulder pain, bilateral elbow and hand and wrist pain. Physical therapy was prescribed for the cervical spine and bilateral upper extremities. An MRI Cervical spine was performed on 9-24-14. On 1-12-15 the IW complains of pain in hands, wrists, elbows, shoulders, and neck and upper back. There is numbness in hands, tingling in hands and wrist; stiffness in hands, wrist, and elbows, shoulders and neck. Also noted is swelling right shoulder. On examination the cervical compression test and distraction tests are normal. There is no significant cervical adenopathy and full range of motion and good strength is reported in the shoulders. The cervical spine shows a loss of the normal cervical lordotic curve and there is some mild to

moderate disc space narrowing at C4-5-6 and these findings are consistent with mild to moderate degenerative changes in the cervical spine. On 2-11-15 a Left Interlaminar Cervical Epidural Steroid Injection was given. Diagnosis was cervical radiculopathy. An evaluation dated 5-5-15 report that the injection in February 2015 alleviated symptoms in both right and left upper extremity for a few weeks. The current symptoms include significant symptoms in her neck. The pain is rated as 8 out of 10. The IW has been utilizing bracing and physical therapy. Treatment during this exam include two intramuscular injections consisting of Vitamin B-12 complex and the second a mix of 1 cc of Marcaine and 2 cc Toradol. Diagnoses: Cervical discopathy, Status post right carpal tunnel release with release of left trigger finger, Left carpal tunnel syndrome, bilateral cubital tunnel syndrome, Double crush syndrome, Cervicalgia and Rule out rotator cuff dysfunction both shoulders Current requested treatments are C5-C7 Anterior Cervical Discectomy and Rigid Fusion, Associated surgical service: Assistant Surgeon, Associated surgical service: Medical Clearance, Associated surgical service: DME purchase of One Minerva mini collar, Associated surgical service: DME ONE Miami J Collar, Associated surgical service: Bone Stimulator.

IMR ISSUES, DECISIONS AND RATIONALES

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

C5-C7 Anterior Cervical Discectomy and Rigid Fusion: Overturned

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck & Upper Back Chapter, Fusion, Anterior cervical.

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Surgical Considerations.

Decision rationale: Per the CA MTUS/ACOEM guidelines, Neck and upper back complaints, pages 181-183 surgery is not recommended for non-radiating pain or in absence of evidence of nerve root compromise. There is evidence of correlating nerve root compromise from the exam of 5/5/15 and benefit from injection. The patient has radiating pain from the exam notes and this does appear to correlate with any imaging findings from 9/24/14. Therefore the patient does meet accepted guidelines for the procedure and the request is medically necessary.

Associated surgical service: Assistant Surgeon: Overturned

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation http://www.aaos.org/about/papers/position/1120.asp.

Decision rationale: CA MTUS/ACOEM/ODG are silent on the issue of assistant surgeon. According to the American College of Surgeons: "The first assistant to the surgeon during a surgical operation should be a trained individual capable of participating and actively assisting

the surgeon to establish a good working team. The first assistant provides aid in exposure, hemostasis, and other technical function which will help the surgeon carry out a safe operation and optimal results for the patient. The role will vary considerably with the surgical operation, specialty area, and type of hospital. There is an indication for an assistant surgeon for a two level cervical fusion. The guidelines state that the more complex or risky the operation, the more highly trained the first assistant should be. In this case the decision for an assistant surgeon is medically necessary.

Associated surgical service: Medical Clearance: Overturned

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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, Preoperative testing.

Decision rationale: CA MTUS/ACOEM and ODG Neck and upper back chapter are silent on the issue of preoperative testing. An alternative chapter in ODG, Low back, Preoperative testing general, is utilized. This chapter states that preoperative testing is guided by the patient's clinical history, comorbidities and physical examination findings. In this case the patient is a 66 year old who would warrant preoperative testing prior to the proposed surgical procedure. Therefore the determination is medically necessary.

Associated surgical service: DME purchase of One Minerva mini collar: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck, Cervical collars.

Decision rationale: CA MTUS/ACOEM is silent on the issue of cervical collars. Per ODG, Neck section, cervical collars, post-operative (fusion) is not recommended after single-level anterior cervical fusion with plate. The use of a cervical brace does not improve the fusion rate or the clinical outcomes of patients undergoing single-level anterior cervical fusion with plating. Plates limit motion between the graft and the vertebra in anterior cervical fusion. Still, the use of cervical collars after instrumented anterior cervical fusion is widely practiced. This RCT found there was also no statistically significant difference in any of the clinical measures between the Braced and Non-braced group. The SF-36 Physical Component Summary, NDI, neck, and arm pain scores were similar in both groups at all-time intervals and showed statistically significant improvement when compared with preoperative scores. There was no difference in the proportion of patients working at any time point. Independent radiologists reported higher rates of fusion in the non-braced group over all time intervals, but those were not statistically

significant. As the guidelines do not support bracing postoperatively, the request is not medically necessary.

Associated surgical service: DME ONE Miami J Collar: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck, Cervical collars.

Decision rationale: CA MTUS/ACOEM is silent on the issue of cervical collars. Per ODG, Neck section, cervical collars, post-operative (fusion) is not recommended after single-level anterior cervical fusion with plate. The use of a cervical brace does not improve the fusion rate or the clinical outcomes of patients undergoing single-level anterior cervical fusion with plating. Plates limit motion between the graft and the vertebra in anterior cervical fusion. Still, the use of cervical collars after instrumented anterior cervical fusion is widely practiced. This RCT found there was also no statistically significant difference in any of the clinical measures between the Braced and Non-braced group. The SF-36 Physical Component Summary, NDI, neck, and arm pain scores were similar in both groups at all-time intervals and showed statistically significant improvement when compared with preoperative scores. There was no difference in the proportion of patients working at any time point. Independent radiologists reported higher rates of fusion in the non-braced group over all time intervals, but those were not statistically significant. As the guidelines do not support bracing postoperatively, the request is not medically necessary.

Associated surgical service: Bone Stimulator: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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, bone growth stimulator.

Decision rationale: CA MTUS/ACOEM is silent on the issue of bone growth stimulator for the cervical spine. According to the ODG Neck and Upper Back, Bone growth stimulator, it is under study. An alternative Guideline, the low back chapter was utilized. This chapter states that bone growth stimulator would be considered for patients as an adjunct to spine fusion if they are at high risk. In this case, the fusion proposed is at one level and there is no high risk factors demonstrated in the records submitted. Therefore the request is not medically necessary.