

Case Number:	CM15-0076730		
Date Assigned:	04/28/2015	Date of Injury:	02/22/2010
Decision Date:	05/28/2015	UR Denial Date:	04/14/2015
Priority:	Standard	Application Received:	04/22/2015

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 53-year-old male who sustained an industrial injury on 2/22/10, relative to a lifting. He was status post left shoulder subacromial decompression and rotator cuff repair on 10/24/12, and left shoulder excision of acromioclavicular joint and distal clavicle in January 2014. The 1/02/15 cervical spine MRI impression documented moderate diffuse osteoarthritic change. At C5/6, there was a 2.5 mm disc bulge and a moderate disc osteophyte complex bilaterally, greater on the left, with moderate bilateral neuroforaminal encroachment and slight thecal sac effacement. At C6/7, there is a loss of disc height. There was a broad-based 1.4 mm to 2.0 mm disc bulge and slight bilateral disc osteophyte complex with bilateral neuroforaminal narrowing. The 1/14/15 cervical spine x-rays impression documented degenerative anterolisthesis of C4 relative to C3. There was disc space narrowing, anterior spurring, endplate sclerosis, and uncovertebral joint hypertonicity extending from C5 to C7. The 2/11/15 orthopedic surgeon report cited continued neck and bilateral arm pain. Physical exam documented 2+ cervical paraspinal muscle spasms and tenderness, and decreased left C5/6 and C6/7 dermatomal sensation. Deep tendon reflexes and motor function were within normal limits. X-rays showed severe degenerative disc disease and disc space collapse at C5/6 and C6/7 with anterior and posterior osteophytes. Imaging documented disc osteophyte complex and degenerative disc disease at C5/6 with bilateral moderate neuroforaminal encroachment. There was slight thecal sac encroachment at C6/7 with loss of disc height, disc bulge, and bilateral disc osteophyte complex with bilateral neuroforaminal narrowing. The diagnosis was cervical spondylotic radiculopathy. The treatment plan recommended anterior cervical discectomy and fusion at C5/6

and C6/7 with interbody cage and cervical plating from C5 to C7. The 4/1/15 treating physician report cited neck pain radiating into the right upper back. The injured worker requested cervical surgery as conservative treatment had not helped. Physical exam documented cervical tenderness to palpation, decreased cervical range of motion, and positive axial compression test. The diagnosis included cervical spondylosis without myelopathy. The treatment plan recommended Norco and noted an AME report was pending. The 4/14/15 utilization review non-certified the request for anterior cervical discectomy and fusion C5/6 and C6/7 as there was no records from the treating surgeon outlining radiculopathy or evidence of neurologic compression consistent with guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Anterior cervical discectomy & fusion @ C5 - C6 and C6- C7 to decompress the nerve roots and stabilize the spine with interbody cage and cervical planting C5-C7 with assistant surgeon: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 166, 180 - 186.

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, anterior cervical; Plate fixation, cervical spine surgery and Other Medical Treatment Guidelines Centers for Medicare and Medicaid services, Physician Fee Schedule: Assistant Surgeons, <http://www.cms.gov/apps/physician-fee-schedule/overview.aspx>.

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 ODG indicate that plate fixation is under study but generally recommend the use of plate fixation for multilevel cervical spine procedures. Evidence based medical guidelines would support the use of an assistant surgeon for this procedure. Guideline criteria have not been met. This patient presents with persistent neck pain radiating into both upper extremities. There was decreased left C5/6 and C6/7 sensation noted. However, clinical exam finding did not document a radicular pain pattern, positive Spurling's test, motor deficit or reflex change, or positive EMG findings that correlated with reported imaging evidence of plausible nerve root compression at C5/6 and C6/7. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. Therefore, this request is not medically necessary at this time.

