

<b>Case Number:</b>	CM13-0048636		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	06/14/2012
<b>Decision Date:</b>	07/29/2014	<b>UR Denial Date:</b>	10/07/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/06/2013

### 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 Surgery and is licensed to practice in Mississippi. 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 61 year-old female who was reportedly injured on 2/21/1997. The mechanism of injury is not listed in these records reviewed. The most recent progress note dated 8/16/2013 indicates that there are ongoing complaints of low back pain, neck pain, bilateral lower extremity pain, and bilateral shoulder pain. The physical examination demonstrated General: alert and oriented in moderate distress. Antalgic gait. Neurologic: sensory exam revealed no change. Motor examination revealed no change. Musculoskeletal: positive bilateral wrist/hand tenderness, left greater than right. No reason diagnostic studies were available for review. Previous treatment includes lumbar surgery, physical therapy, acupuncture, and medications to include, Vicodin, naproxen and Nexium. A request was made for anterior cervical fusion c5-c7 per 9-19-13 report quantity two, anterior cervical discectomy with decompression c5-c7 per 9-19-13 report quantity two anterior instrumentation: 2 to 3 vertebral segments quantity two allograft quantity one local bone morphogenic protein quantity one assistant surgeon quantity one inpatient length of stay two days quantity two and was not certified in the pre-authorization process on 8/19/2013.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Anterior cervical fusion C5-C7 PER 9-19-13 report quantity (2): Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

**Decision rationale:** After review of the medical records submitted I was unable to identify any objective clinical findings of chronic radiculopathy due to nerve root involvement with minimal comments documented in the physical exam section. Therefore, the above request for surgery is not medically necessary due to limited documentation.

**Anterior cervical discectomy with decompression C5-C7 PER 9-19-13 report quantity (2):**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

**Decision rationale:** Anterior Cervical Discectomy is 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. After review of the medical records submitted I was unable to identify any objective clinical findings of chronic radiculopathy due to nerve root involvement with minimal comments documented in the physical exam section. Therefore, the above request for surgery is not medically necessary due to limited documentation.

**Anterior Instrumentation: 2 to 3 vertebral segments quantity (2):** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

**Decision rationale:** Cervical discectomy with fusion is recommended for patients with subacute or chronic radiculopathy due to ongoing nerve root compression who continue to have significant pain and functional limitation after at least 6 weeks of time and appropriate non-operative treatment. The decision to use special instrumentation should be left up to the decision of the surgeon performing the procedure. After review of the medical records the requested procedure has not been approved by the insurance carrier at this time. Therefore, the need for specialized instrumentation is not medically necessary.

**Allograft quantity (1):** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**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 (Acute & Chronic), allograft transplantation.

**Decision rationale:** Allograft Transplantation Is not recommended until further research is completed. It is still investigational. In this very small study, the motion and stability of the spinal unit was preserved after transplantation of fresh-frozen allogenic intervertebral discs. With further refinements, such transplantations might be a feasible surgical alternative to spinal fusion or artificial disk replacement, especially in younger patients, but more research is required. After reviewing the medical records and Official Disability Guidelines it seems this treatment is deemed investigational and there is not enough supporting data/clinical research to establish medically necessity at this time. Therefore, this procedure is not medically necessary.

**Local Bone Morphogenic Protein Quantity (1): Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**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 (Acute & Chronic), Bone-morphogenetic protein (BMP).

**Decision rationale:** Bone Morphogenic Protein (BMP) is not recommended. There is a lack of clear evidence of improved outcomes with BMP, and there is inadequate evidence of safety and efficacy to support routine use. (Carragee, 2009). The use of BMP may be off-label in clinical practice in up to 85% of procedures. (Ong, 2010) Complications are significant with off-label use, and application in the cervical spine has been associated with significant complications including respiratory and swallowing. (Mroz, 2010). It is also not recommended for use in anterior cervical fusions. After reviewing the medical records and ODG guidelines it seems there is inadequate information concerning safety and efficacy to support the use of this product. It is deemed Investigational and there is not enough supporting data/clinical research to establish medical necessity at this time. Therefore, this procedure is not medically necessary.

**Assistant Surgeon Quantity (1): Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**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) surgical assistant, Back to ODG - TWC Index (updated 07/03/14).

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Inpatient Length Of Stay Two Days Quantity (2): Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**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 (Acute & Chronic), hospital length of stay.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.