

<b>Case Number:</b>	CM14-0094511		
<b>Date Assigned:</b>	07/25/2014	<b>Date of Injury:</b>	08/05/2009
<b>Decision Date:</b>	11/12/2014	<b>UR Denial Date:</b>	06/02/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/20/2014

### 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 Surgery, has a subspecialty in Spine Fellowship and is licensed to practice in California. 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:

According to the records made available for review, this is a 48-year-old female with a 6/5/09 date of injury. At the time (4/23/14) of the request for authorization for two level anterior cervical fusion, C5-6 and C6-7 with 3 day inpatient stay, there is documentation of subjective (continuous neck pain, with pain radiating to the shoulders and upper back) and objective (palpation elicits spasms of the paracervical muscles bilaterally, decreased cervical spine range of motion, Spurling's test is positive bilaterally, left biceps reflex 1 and right 2, diminished sensation over the right C5-6 and C7 dermatome distribution) findings, imaging findings (MRI cervical spine (4/21/14) report revealed at C5-6 moderate right neural foraminal narrowing. At C6-7 there is no central canal or neural foraminal narrowing), current diagnoses (cervical spinal stenosis, cervical radiculitis, and cervical sprain), and treatment to date (chiropractic therapy, medication, and epidural steroid injections). There is no documentation of clear imaging evidence of a lesion at the C6-7 level that has been shown to benefit from surgical repair in both the short and the long term.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Two level anterior cervical fusion, C5-6 and C6-7 with 3 day inpatient stay:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 179. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back Chapter, <http://odg-twc.com/odgtwc/neck.htm>

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 180. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back, Discectomy/laminectomy/laminoplasty; Fusion, anterior cervical and Hospital length of stay

**Decision rationale:** MTUS reference to ACOEM guidelines identifies documentation of persistent, severe, and disabling shoulder or arm symptoms; activity limitation for more than one month or with extreme progression of symptoms; clear clinical, imaging, and electrophysiology evidence, consistently indicating the same lesion that has been shown to benefit from surgical repair both in the short and the long term; and unresolved radicular symptoms after receiving conservative treatment, as criteria necessary to support the medical necessity of cervical decompression. ODG identifies documentation of failure of at least a 6-8 week trial of conservative care, etiologies of pain such as metabolic sources (diabetes/thyroid disease) non-structural radiculopathies (inflammatory, malignant or motor neuron disease), and/or peripheral sources (carpal tunnel syndrome) should be addressed prior to cervical surgical procedures, evidence of sensory symptoms in a cervical distribution that correlate with the involved cervical level or presence of a positive Spurling test, evidence of motor deficit or reflex changes or positive EMG findings that correlate with the cervical level, an abnormal imaging (CT/myelogram and/or MRI) study with positive findings that correlate with nerve root involvement, as criteria necessary to support the medical necessity of cervical decompression. In addition, ODG identifies anterior cervical fusion is recommended as an option in combination with anterior cervical discectomy for approved indications. Specifically regarding inpatient stay, MTUS does not address the issue. ODG identifies hospital LOS for up to 2 days in the management of anterior cervical fusion. Within the medical information available for review, there is documentation of diagnoses of cervical spinal stenosis, cervical radiculitis, and cervical sprain. In addition, there is documentation of persistent, severe, and disabling shoulder or arm symptoms; activity limitation for more than one month; clear clinical and imaging evidence, consistently indicating the same lesion at the C5-6 level that has been shown to benefit from surgical repair both in the short and the long term; and unresolved radicular symptoms after receiving conservative treatment. However, given the documented imaging findings (MRI cervical spine (4/21/14) report revealed at C5-6 moderate right neural foraminal narrowing. At C6-7 there is no central canal or neural foraminal narrowing), there is no documentation of clear imaging evidence of a lesion at the C6-7 level that has been shown to benefit from surgical repair in both the short and the long term. In addition, the requested 3 day inpatient stay exceeds guidelines. Therefore, based on guidelines and a review of the evidence, the request for two level anterior cervical fusion, C5-6 and C6-7 with 3 day inpatient stay is not medically necessary.