

<b>Case Number:</b>	CM15-0143311		
<b>Date Assigned:</b>	08/04/2015	<b>Date of Injury:</b>	12/03/2011
<b>Decision Date:</b>	09/22/2015	<b>UR Denial Date:</b>	07/15/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	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: 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:

This injured worker is a 40-year-old male who sustained an industrial injury on 12/03/11. Injury occurred when he was helping a co-worker transfer a large patient from the chair to the bed. The patient fell from his grasp, causing him to fall and land on top of the bed rails. Conservative treatment included medications, activity modification, and physical therapy. The 6/8/15 cervical spine MRI revealed mild to moderate multilevel degenerative disc disease with straightening of the cervical spine, multilevel spinal canal stenosis and bilateral neural foraminal narrowing, and normal cervical spinal cord signal intensity. At C5/6, there was a 3 mm broad-based posterior disc osteophyte complex. There was moderate central canal stenosis (7 mm AP dimension) with effacement of the anterior CSF space. There was bilateral uncovertebral joint and facet hypertrophy, and mild bilateral neuroforaminal narrowing. At C6/7, there was a 3 mm broad-based posterior disc osteophyte complex with moderate central canal stenosis (8 mm AP dimension). There was moderate left and mild right neuroforaminal narrowing. The 7/9/15 treating physician report cited a flare-up of intermittent, moderate neck pain radiating to both arms with numbness and tingling. He had difficulty rotating his head and neck. Physical exam documented increased muscle tone with associated tenderness about the paracervical and trapezius muscle, and some guarding on exam. Neurologic exam documented decreased left C5, C6, and C7 sensation, absent right biceps reflex, and diminished right brachioradialis and triceps reflexes. Motor testing documented weakness over the left deltoid, biceps, triceps, thumb abductors, and interossei small finger. Imaging showed mild to moderate multilevel degenerative disc disease with straightening of the cervical spine, multilevel central canal stenosis and

bilateral neuroforaminal narrowing, and normal cervical spinal cord signal. Authorization was requested for anterior cervical disc fusion of C5/6 and C6/7, assistant surgeon, pre-op medical clearance, post-op 30 day rental of cryotherapy unit, and bone growth stimulator purchase. The 7/15/15 utilization review non-certified the request for ACDF at C5/6 and C6/7 and associated surgical services as clinical findings did not fully correlate with imaging, and detailed evidence of conservative treatment was not provided.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Anterior Cervical Disc Fusion of C5-C6 and C6-C7: Overturned**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

**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.

**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) provide 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. If there is no evidence of sensory, motor, reflex or EMG changes, confirmatory selective nerve root blocks may be substituted if these blocks correlate with the imaging study. The block should produce pain in the abnormal nerve root and provide at least 75% pain relief for the duration of the local anesthetic. Guideline criteria have been met. This injured worker presents with worsening neck pain radiating into both upper extremities with tingling. Clinical exam findings are consistent with imaging evidence of plausible nerve root compromise. There is evidence of motor deficit and reflex changes. Detailed evidence of at least 6 to 8 weeks of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. Therefore, this request is medically necessary.

#### **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 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 MTUS guidelines do not address the appropriateness of assistant surgeons. The Center for Medicare and Medicaid Services (CMS) provide direction relative to the typical medical necessity of assistant surgeons. The Centers for Medicare & Medicaid Services (CMS) has revised the list of surgical procedures which are eligible for assistant-at-surgery. The procedure codes with a 0 under the assistant surgeon heading imply that an assistant is not necessary; however, procedure codes with a 1 or 2 implies that an assistant is usually necessary. For this requested surgery, CPT codes 22551 and 22845, there is a 2 in the assistant surgeon column for each code. Therefore, based on the stated guideline and the complexity of the procedure, this request is medically necessary.

**Pre-op Medical Clearance:** 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 Institute for Clinical Systems Improvement (ICSI). Preoperative evaluation. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2010 Jun. 40 p.

**Decision rationale:** The California MTUS guidelines do not provide recommendations for pre-operative medical clearance. Evidence based medical guidelines indicate that a basic pre-operative assessment is required for all patients undergoing diagnostic or therapeutic procedures. Middle-aged males have known occult increased medical/cardiac risk factors. Guideline criteria have been met based on patient age, magnitude of surgical procedure, recumbent position, fluid exchange and the risks of undergoing anesthesia. Therefore, this request is medically necessary.

**Post-op 30 day rental of Cryotherapy unit:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 174. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back: Continuous flow cryotherapy; Heat/cold applications.

**Decision rationale:** The California MTUS are silent regarding cold therapy devices, The Official Disability Guidelines do not recommend the use of continuous flow cryotherapy in the neck. Guidelines recommend heat and cold applications using heat and cold packs. Guideline criteria have not been met. There is no compelling rationale presented to support the medical necessity of a cold therapy unit over standard cold packs. Therefore, this request is not medically necessary.

**Associated Surgical Service: Bone Growth Stimulator purchase: 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) Neck and Upper Back: Bone-growth stimulators (BGS).

**Decision rationale:** The California MTUS guidelines are silent regarding bone growth stimulators. The Official Disability Guidelines indicate that the use of bone growth stimulation remains under study for the cervical spinal fusion. Bone growth stimulators may be considered medically necessary as an adjunct to lumbar fusion for patients with any of the following risk factors for failed fusion: one or more previous failed spinal fusion(s); grade III or worse spondylolisthesis; multilevel fusion; current smoking habit; diabetes, renal disease, or alcoholism; or significant osteoporosis. Guideline criteria have not been met. This injured worker is certified for a 2-level anterior cervical discectomy and fusion. Guidelines support the use of bone growth stimulator for patients undergoing multilevel. Therefore, this request is medically necessary.