Case Number:	CM15-0145895		
Date Assigned:	08/07/2015	**Date of Injury:**	10/09/2013
Decision Date:	09/04/2015	**UR Denial Date:**	07/02/2015
Priority:	Standard	**Application Received:**	07/28/2015

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 54-year-old male who sustained an industrial injury on 10/09/13. Injury occurred when he slipped and braced his fall with his left hand down. Past surgical history was positive for left cubital tunnel release in 2013. The 1/22/15 cervical spine MRI impression documented severe degenerative disc disease within the cervical spine superimposed on underlying congenital spinal stenosis. At C3/4, there was a 2 mm disc osteophyte complex with moderate to severe central canal narrowing (AP diameter 6-7 mm), mild flattening of the anterior aspect of the cord, facet arthropathy and uncovertebral hypertrophy contributed to severe foraminal narrowing on the right with encroachment of the exiting nerve root, and moderate left foraminal narrowing. At C4/5, there was a 3-4 mm diffuse disc bulge/osteophyte complex with severe narrowing of the central canal (AP diameter 4-5 mm), with flattening of the left anterior aspect of the cord, and severe foraminal narrowing on the left, relatively mild on the right. At C5/6, there was a 5-6 mm diffuse disc bulge/osteophyte complex with severe central canal stenosis (AP diameter 4 mm), with flattening of the ventral aspect of the cord. There was increased signal intensity within the cord at this level that could represent edema and/or myelomalacic changes. There was severe foraminal narrowing bilaterally with encroachment on the exiting nerve roots. At C6/7, there was a 4-5 mm diffuse disc bulge/osteophyte complex slightly asymmetric to the left paracentral foraminal region with moderate central canal stenosis, severe left and moderate to severe right neuroforaminal with encroachment on the exiting nerve root. At C7/T1, there was a 3 mm broad-based disc bulge/osteophyte complex slightly asymmetric to the right paracentral region with moderate central canal stenosis, severe left and

moderate to severe right foraminal narrowing with encroachment on the exiting nerve roots. The 3/12/15 orthopedic surgeon reported cited continued left forearm pain, which was unresponsive to release of the ulnar nerve. He complained of numbness into the hand into the C7 and C8 distribution, ulnar distribution. Cervical spine imaging was reviewed with changes noted at the C5/6, C6/7 and C7/T1 levels. There were changes at C5/6 that suggested a degree of myelomalacia and severe foraminal narrowing with encroachment on the exiting nerve roots at the C5/6 and C6/7 levels. Physical exam documented a slightly positive Spurling's sign and slightly positive cervical distraction sign. There was decreased left hand sensation over the C7 and C8 dermatomes with reasonable hand physical function, 4/5 strength. Deep tendon reflexes were equal bilaterally and upper extremity motor strength was normal. The injured worker had not improved with cubital tunnel release surgery so quite likely there were issues with cervical radiculopathy. Updated EMG/NCV study was recommended. The 5/14/15 bilateral upper extremity EMG/NCV study was reported as normal. The 5/28/15 treating physician report cited complaints of left arm pain, with constant moderate achy left elbow pain with weakness, and left wrist pain. Physical exam documented normal left elbow and wrist range of motion with tenderness to palpation over the medial epicondyle. The diagnosis included tardy ulnar nerve palsy, psychological stress, left medial epicondylitis, status post left elbow surgery, left wrist sprain/strain, muscle weakness, weight gain, and sleep disturbance. The treatment plan included medications, x-rays of the left elbow and hand, psychological consultation, internal medicine consultation, and authorization for anterior cervical fusion at C4/5 and C5/6. The injured worker was capable of modified duty. The 7/2/15 utilization review non-certified the request for anterior cervical fusion at C4/5 and C5/6 as there was no specific objective or electrodiagnostic findings to support the diagnosis of cervical rheumatoid arthritis, no evidence that conservative treatment had been exhausted, and no evidence of instability on exam or diagnostic studies.

IMR ISSUES, DECISIONS AND RATIONALES

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

Anterior Cervical Fusion C4-C5 & C5-C6: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 209-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back: Fusion, anterior cervical.

Decision rationale: The California Medical Treatment Utilization Schedule guidelines provide a general recommendation for cervical fusion surgery, including consideration of pre-surgical psychological screening. Guidelines require documented failure of conservative treatment to resolve radicular symptoms and clear clinical, imaging, and electrophysiologic evidence, consistently indicating the same lesion that has been shown to benefit from surgical repair in both the short- and long-term. The Official Disability Guidelines recommend anterior cervical fusion for spondylotic myelopathy based on clinical signs and/or symptoms (Clumsiness of hands, urinary urgency, new-onset bowel or bladder incontinence, frequent falls, hyperreflexia, Hoffmann sign, increased tone or spasticity, loss of thenar or hypothenar eminence, gait

abnormality or pathologic Babinski sign) and diagnostic imaging (i.e., MRI or CT myelogram) demonstrating spinal cord compression. Anterior cervical fusion is also supported for cervical nerve root compression verified by diagnostic imaging and resulting in severe pain or profound weakness of the extremities. Guideline criteria have not been met. This injured worker presents with left arm pain that failed to improve with cubital tunnel release surgery. Previous clinical exam findings evidenced a slightly positive Spurling's test with sensory deficit over the C7 and C8 distribution. There is imaging evidence of nerve root compression at the C5/6 and C6/7 levels, and findings suggestive of myelomalacia at the C5/6 levels. There are no clinical signs or symptoms of myelopathy. The bilateral upper extremity electrodiagnostic study was reported as normal. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. There is evidence of potential psychological issues with no evidence of psychosocial screening for surgery. There is no clear clinical or electrodiagnostic evidence to support this request for C4/5 and C5/6 anterior cervical fusion at this time. Therefore, this request is not medically necessary.