Case Number:	CM15-0164463		
Date Assigned:	09/01/2015	**Date of Injury:**	09/27/1989
Decision Date:	10/05/2015	**UR Denial Date:**	08/13/2015
Priority:	Standard	**Application Received:**	08/21/2015

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 62-year-old male who sustained an industrial injury on 9/27/89. The mechanism of injury was not documented. Past medical history was positive for elevated cholesterol and hypertension. He underwent left C5/6 laminoforaminotomy in January 2013. The 6/1/15 treating physician report cited an onset of new weakness in the left hand and difficulty grasping and holding objects. Neck pain radiating into the left upper extremity to the hand had been present for years. Symptoms were constant and worsened by neck range of motion, and alleviated by nothing. Upper extremity motor exam documented 4/5 interosseous weakness on the left, depressed left triceps and biceps reflexes, symmetrical lower extremity deep tendon reflexes with no clonus, normal heel-toe gait, normal sensation, and negative Romberg's. There were changes in his neurologic exam including reflex change and new left hand weakness. Updated MRI was recommended. The 6/17/15 cervical spine MRI impression documented fusion of the left C5/6 facets with some mild active facet arthritis on the left at C4/5. There were central posterior disc protrusions at the C3/4 and C4/5 levels abutting the cord with left posterior paramedian osteophytic ridging indenting the cord at C5/6 and left posterior disc protrusion at C7/T1 abutting the anterior margin of the cord on the left. There was multilevel foraminal narrowing with the most severe foraminal narrowing on the left at C6/7 and C7/T1 including an intraforarminal disc extrusion at C6/7. The 7/17/15 electrodiagnostic study documented mild to moderate left carpal tunnel syndrome, right median mononeuropathy, and chronic left C5 radiculopathy. The treating physician indicated that he appeared to be most symptomatic from his electrodiagnostically documented left carpal tunnel syndrome. His opponens weakness was not likely to respond to bracing. Left carpal tunnel release was

recommended. The 7/20/15 treating physician report indicated that he was awakened at night with numbness in the hand. He also had hand weakness and was frequently dropping things. Conservative treatment included activity modification, medications, chiropractic, and physiotherapy. The 8/6/15 treating physician report cited 7.5/10 neck pain radiating into the left arm with paresthesias and weakness. Physical exam documented 4/5 left interosseous and opponens pollicis weakness diminished left triceps reflex, 2+ to 3+ lower extremity deep tendon reflexes, and negative Tinel's at the wrists and elbows. The diagnosis included cervical radiculopathy, degenerative disc disease of the cervical spine with myelopathy, and carpal tunnel syndrome. The injured worker had significant degenerative disc disease extending from C5-C7 that are responsible at least in part for his on-going symptoms. He had failed conservative treatment. Authorization was requested for anterior microdiscectomy C5/6, C6/7, C7/T1 with bone bank fusion anterior plate and associated 2-day hospital length of stay. The 8/13/15 utilization review non-certified the request for anterior microdiscectomy C5/6, C6/7, C7/T1 with bone bank fusion anterior plate and associated 2-day hospital length of stay and associated hospital stay as the outcome of the carpal tunnel release should be assessed prior to consideration of a multilevel fusion, there was no detailed evidence of conservative treatment failure, there was no evidence of psychological evaluation, and there was no indication as to what had changed in the injured worker's clinical presentation to necessitate the need for this surgery at this time.

IMR ISSUES, DECISIONS AND RATIONALES

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

Anterior Microdiscectomy C5-6, C6-7, C7-T1 with Bone Bank Fusion Anterior Plate: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back 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) 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. 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 chronic neck pain radiating into the left upper extremity with numbness and weakness. A flare-up was documented in June 2015 with worsening neurologic changes relative to weakness and reflexes. Clinical exam findings are consistent with imaging evidence of plausible cord compression at the C5/6 through C7/T1 levels. Clinical exam findings were negative for carpal tunnel provocative testing. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. There were no psychological issues documented. Therefore, this request is medically necessary.

Associated surgical service: 2 Day Hospital Stay: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 11th Edition (web), Neck and Upper Back Chapter, Hospital Length of Stay.

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: Hospital length of stay (LOS).

Decision rationale: The California MTUS does not provide hospital length of stay recommendations. The Official Disability Guidelines generally recommend the median length of stay (LOS) based on type of surgery, or best practice target LOS for cases with no complications. The recommended median and best practice target for cervical anterior fusion is 1 days. However, the mean length of stay is documented as 2.2 days. Given the 3-level anterior cervical discectomy and fusion being planned, a two-day length of stay is medically reasonable and appropriate. Therefore, this request is medically necessary.