

<b>Case Number:</b>	CM15-0166566		
<b>Date Assigned:</b>	09/04/2015	<b>Date of Injury:</b>	03/29/2001
<b>Decision Date:</b>	10/08/2015	<b>UR Denial Date:</b>	07/25/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/25/2015

### 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 47-year-old female who sustained an industrial injury on 3/29/01. Injury occurred when she fell off a chair and hit her back and head on the floor. Surgical history was positive for cervical spine surgeries, including fusion from cervical fusion at C5-C7 on 9/29/09. Conservative treatment included physical therapy, TENS, and medication. The 5/14/15 cervical spine MRI impression documented a posterior disc protrusion, osteophyte complex at the narrowed C4/5 interspace that protruded about 1.2 mm beyond the adjacent vertebral body margin and did not cause any neuroforaminal narrowing. At C5/6 and C6/7, there was central posterior artifact with preserved neural foramina and anterior internal fixation plate and vertebral screws from prior surgery. The 6/10/15 spine surgery report indicated that the injured worker was status post fusion from C5 to C7, and had developed instability, stenosis and spondylolisthesis at the C4/5 level. This had been diagnosed several years ago, and additional surgery had been held off. Unfortunately, it had gotten worse and the disc was now effacing the adjacent anterior thecal sac with neural compression. She had failed extensive conservative treatment. Surgery was recommended. The 7/3/15 treating physician report cited grade 8-9/10 neck pain radiating to the scapula region with headaches. She was having difficulty working and experienced insomnia. Medications were providing about 30% pain relief but she was not able to take them at work. She was also using a TENS unit with some benefit, especially at work. She recently developed a deep depression and had been treated with Prozac for the past 3 weeks. Spurling's was positive on the left causing tingling in the 4th and 5th fingers. Physical exam documented decreased cervical range of motion, mild tenderness to palpation, 3/4 bilateral upper and lower extremity deep tendon reflexes, normal gait, and decreased sensation from the 4th and 5th left fingers to the medial forearm and upper arm. The diagnosis included status post cervical

fusion C5-7 with left cervical radiculopathy. Authorization was requested for a psychological consultation and C4-5 anterior discectomy and fusion with instrumentation and exploration from C5-C7. The 7/26/15 utilization review certified the request for a psychological consultation. The request for C4-5 anterior discectomy and fusion with instrumentation and exploration from C5-C7 was non-certified as there was an absence of definitive evidence of instability, significant functional limitation, cervical radiculopathy, or neurologic deficits relative to C4/5, and the fusion at C5-C7 appeared solid with intact hardware. The 8/14/15 spine surgery report cited progressive neck pain with left upper extremity radiculopathy and occasional balance issues. Physical exam documented restricted and painful cervical range of motion, tenderness to palpation from C3 to C6, minimal paraspinal muscle and facet joint tenderness, and minimal occiput and lower cervical tenderness. She had 5/5 upper extremity motor strength, deep tendon reflexes 3+ throughout, and positive Hoffman's bilaterally. X-rays were obtained and showed no significant coronal plane imbalance. There appeared to be solid fusion at C5/6 and C6/7. There was uncovertebral spurring at C4/5 with large anterior and posterior spurs. There was no lucency around the hardware. Flexion/extension films showed no transitory instability. There was mildly increased kyphosis at C4/5 from flexion to extension. Imaging was reviewed and showed posterior spurring and disc protrusion at C4/5 with foraminal narrowing more severe on the left with likely neural compression of the exiting nerve root. Surgery had been denied. Physical therapy was ordered for 12 visits for pain relief and functional improvement.

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

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

#### **C4-5 anterior discectomy and fusion with instrumentation and exploration from C5-C7: Overturned**

**Claims Administrator guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004, and Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Surgical Considerations. 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. Guideline criteria have been met. This injured worker presents with progressive cervical spine pain with left upper extremity radiculopathy and a positive Spurling's test. There are significant functional difficulties noted. Clinical exam findings were consistent with imaging evidence of plausible neural compression. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. There is evidence of increased kyphosis on flexion/extension films. A psychological

consultation has been requested and certified to address psychological issues. Therefore, this request is medically necessary.