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| <b>Case Number:</b>   | CM15-0180393 |                              |            |
| <b>Date Assigned:</b> | 09/22/2015   | <b>Date of Injury:</b>       | 03/01/2014 |
| <b>Decision Date:</b> | 11/25/2015   | <b>UR Denial Date:</b>       | 08/26/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 09/14/2015 |

### 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: Minnesota, Florida

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:

The injured worker is a 58 year old male with an industrial injury date of 03-01-2014. Medical records indicate he is being treated for cervical -lumbar discopathy, carpal tunnel-double crush syndrome and cervicgia (03-03-2015). In the treatment note dated 07-28-2015 the treating physician documented the injured worker continued to have pain, numbness and weakness mostly in the cervical 6 and somewhat in the cervical 5 distribution. "MRI (date unavailable) scan was done, which showed significant disease at the cervical 4-5 and cervical 5-6 levels causing spinal cord compression as well as foraminal narrowing." The treating physician also documented the injured worker was somewhat better with Naprosyn but was developing significant gastrointestinal problems. "I think due to the severity of his problems, surgical decompression would be a reasonable alternative." Prior treatment included "exercise programs, physical therapy, 12 aquatic therapy sessions and anti-inflammatory drugs." Work status (03-03-2015) is documented as working full duties and may continue to do so. In the 05-15-2014 note the treating physician documented the results of MRI scan(date unavailable) "It showed moderately severe spinal stenosis at the cervical 4-5 and cervical 5-6 levels with significant canal stenosis with no spinal canal left around the spinal cord. There was bilateral foraminal stenosis, most prominent at the cervical 4-5 and cervical 5-6 levels and to a lesser degree at the cervical 6- 7 level."On 08-26-2015 the request for anterior cervical discectomy and fusion C4-5, C5-6 with partial corpectomy was non-certified by utilization review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Anterior cervical discectomy and fusion C4-5, C5-6 with partial corpectomy: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Indications for Surgery.

**MAXIMUS guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Surgical Considerations.

**Decision rationale:** The injured worker is a 58-year-old male with a date of injury of 3/1/2014. According to an agreed medical examination of 10/16/2014, he was complaining of neck pain with radicular symptoms to the head with associated headaches. Numbness and tingling were not present. The pain was completely relieved after resting and by taking aspirin. On examination sensation to pinprick and light touch was slightly increased in the left upper arm and forearm and intact in the right upper extremity. Biceps, triceps, wrist extensors and flexor digitorum profundus were 5/5, strong and equal. Hand intrinsics were 4/5 bilaterally. Biceps, triceps, and brachioradialis reflexes were 2/4 and equal. X-rays of the cervical spine dated 10/16/2014 revealed moderately severe degenerative changes in the mid and lower cervical spine. EMG and nerve conduction studies of bilateral upper extremities were performed on 11/7/2014. The EMG of the upper extremities and cervical paraspinal muscles was normal. Nerve conduction studies showed moderate slowing of the median sensory distal latencies bilaterally with moderate slowing through the carpal tunnel on the left and absent sensory conduction on the right. In addition there was involvement of the ulnar nerves indicating a sensory motor polyneuropathy. A subsequent follow-up examination by the provider on March 3, 2015 indicates complaint of neck pain with radiation into the upper extremities, left greater than right with associated tingling and numbness. A subsequent MRI scan of the cervical spine dated 7/8/2015 indicated a 2 mm central protrusion of the disks at C3-4, C6-7, and C7-T1 without any significant central spinal or foraminal stenosis at any level, 3 mm central disc/osteophyte complex at C4-5 with mild direct cord compression, a mild bilateral facet arthropathy, mild central spinal, right foraminal and mild to moderate left foraminal stenosis, 3 mm central to right paracentral disc/osteophyte complex at the C5-6 interspace without cord compression, a mild bilateral facet arthropathy and a moderate right and mild left foraminal stenosis. California MTUS guidelines indicate surgical considerations for severe spinovertebral pathology, severe debilitating symptoms with physiologic evidence of specific nerve root or spinal cord dysfunction corroborated on appropriate imaging studies that did not respond to conservative therapy, 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 electrophysiologic evidence, consistently indicating the same lesion that has been shown to benefit from surgical repair in both the short and long-term and unresolved radicular symptoms after receiving conservative treatment. The documentation provided does not indicate objective neurologic deficit. EMG and nerve conduction studies were negative for radiculopathy. There is no documentation of clinical, electrophysiologic, and MRI evidence of the same lesion that is known to benefit in both the short and long-term from surgical intervention. As such, the surgical request does not meet the guideline criteria and the medical necessity of the request has not been substantiated.