

<b>Case Number:</b>	CM15-0182349		
<b>Date Assigned:</b>	09/23/2015	<b>Date of Injury:</b>	08/10/2012
<b>Decision Date:</b>	10/28/2015	<b>UR Denial Date:</b>	09/03/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/16/2015

### 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 36-year-old female who sustained an industrial injury on 8/10/12. She reported an onset of right shoulder and neck pain relative to repetitive pushing, pulling and reaching while working on an assembly line. The 1/11/13 bilateral upper extremity electrodiagnostic study findings were suggestive of bilateral mild carpal tunnel syndrome with no significant cervical radiculopathy. She subsequently underwent right carpal tunnel release in 4/24/14. Conservative treatment had included activity modification, acupuncture, physical therapy, home exercise, oral and topical medications, and C5/6 epidural steroid injections. The 7/22/15 cervical spine MRI impression documented small central disc protrusions at C2/3 and C3/4, and small left paracentral disc protrusions at C4/5 and C5/6. Findings documented 3 mm left paracentral disc protrusions at C3/4 and C5/6 touching the cervical spinal cord with the bilateral neural foramina widely patent. The 8/25/15 spinal surgeon report cited mainly right sided neck pain, pain in the trapezius, and new onset of cramping in the right trapezius musculature, with radiating dysesthesias in the right upper extremity, primarily in a C6 distribution. She takes Lyrica nightly for pain relief. Physical exam documented a stable and steady gait, fairly well maintained cervical range of motion, right paracervical muscle pain, and right trapezius muscle cramping with tenderness to palpation. There were radiating dysesthesias in a C6 distribution and slight decreased right hand sensation. She had 5/5 strength, minimal biceps and brachioradialis reflexes, and no long tract findings. Imaging showed a left paracentral disc protrusion contacting the anterior cervical cord and contributing to mild to moderate stenosis. There was no evidence of myelomalacia or other significant neurologic compression. The diagnosis was C5/6 stenosis with right upper extremity radiculopathy,

refractory to conservative treatment. She had failed extensive conservative treatment included physical therapy, medications, and epidural steroid injection. The most recent cervical epidural steroid injection had not provided relief. Surgery was recommended to include anterior cervical discectomy and fusion C5/6 with PEEK cage, plate and auto/allograft. The 8/31/15 treating physician report cited cervical axial pain and right cervical radiculitis. She was taking Lyrica which was helping with her symptoms. Spurling's test was positive on the right. Cervical range of motion was mildly limited. Lhermitte sign was negative. Neurologic exam documented normal upper extremity strength, sensation, and deep tendon reflexes. The diagnosis was cervical axial pain and cervical radiculitis secondary to C5/6 neuroforaminal narrowing. Authorization was requested for anterior cervical discectomy and fusion C5/6 with PEEK cage, plate and auto/allograft, pre-operative laboratory tests including CBC (complete blood count) nares culture for MRSA (methicillin resistant staph aureus) , PTT (partial thromboplastin time), PT (prothrombin time), and INR (international normalized ratio), and 23-hour inpatient stay. The 9/13/15 utilization review non-certified the anterior cervical discectomy and fusion C5/6 with PEEK cage, plate and auto/allograft and associated surgical requests as the documentation failed to show that the injured worker had evidence of radiculopathy or that symptoms were in a specific dermatomal or myotomal distribution to support the request.

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

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

#### **Anterior Cervical Disc Fusion C5-6 peek cage, plate, aulo/allograft: Overturned**

**Claims Administrator guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004. 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) 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 neck pain radiating into the right upper extremity consistent with C6 radiculopathy. Spurling's sign is positive. Clinical exam findings are consistent with imaging evidence of plausible nerve root compromise at the level of C5/6. Detailed evidence of a recent, reasonable and/or

comprehensive non-operative treatment protocol trial and failure has been submitted. Therefore, this request is medically necessary.

**Preoperative laboratory, CBC (complete blood count), nares culture for MRSA (methicillin resistant staph aureus, PTT (partial thromboplasin time), PT (prothrombin time), INR (international normalized ratio):** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Practice advisory for preanesthesia evaluation: an updated report by the American Society of Anesthesiologists Task Force on Preanesthesia Evaluation. *Anesthesiology* 2012 Mar; 116(3):522-38; Kim DH, Spencer M, Davidson SM, Li L, Shaw JD, Gulczynski D, Hunter DJ, Martha JF, Miley GB, Parazin SJ, Dejoie P, Richmond JC. Institutional prescreening for detection and eradication of methicillin-resistant *Staphylococcus aureus* in patients undergoing elective orthopaedic surgery. *J Bone Joint Surg Am.* 2010 Aug 4;92(9):1820-6. doi: 10.2106/JBJS.I.01050. Epub 2010 Jul 7.

**Decision rationale:** The California MTUS guidelines do not provide recommendations for this service. Evidence based medical guidelines indicate that most laboratory tests are not necessary for routine procedures unless a specific indication is present. Indications for such testing should be documented and based on medical records, patient interview, physical examination, and type and invasiveness of the planned procedure. Peer-reviewed literature supports prescreening for the identification and eradication of methicillin-resistant and methicillin-sensitive *Staphylococcus aureus* carrier status among patients undergoing elective orthopaedic surgery which can lead to significant reductions in postoperative rates of surgical site infection. Guideline criteria have been met based on patient age, long-term use of non-steroidal anti-inflammatory drugs, magnitude of surgical procedure, and the risks of undergoing anesthesia. Therefore, this request is medically necessary.

**23 Hour inpatient 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.

**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 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 anterior cervical discectomy and fusion was 1 day. Guideline criteria have been met for inpatient length of stay up to 1 day. Therefore, this request is medically necessary.