

<b>Case Number:</b>	CM15-0024607		
<b>Date Assigned:</b>	02/17/2015	<b>Date of Injury:</b>	06/16/2011
<b>Decision Date:</b>	04/02/2015	<b>UR Denial Date:</b>	01/30/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/09/2015

### 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:

The injured worker is a 51-year-old female with a date of injury of 6/18/11. The mechanism of injury was noted as cumulative trauma. The 6/17/11 cervical spine x-ray documented mild degenerative changes at C5/6 and C6/7. Records documented a 12/20/13 cervical spine MRI showing interval decrease in the size of the disc herniation at C6/7, otherwise no significant interval changes. Progress reports from 1/6/14 to present suggesting progressive weakness in a left C7 distribution. The 1/14/15 treating physician report cited localized constant neck pain and radicular arm pain. Pain was reported with neck motion and activities of daily living, with no signs of myelopathy or bowel/bladder symptoms. Complaints included decreased neck range of motion, and left arm numbness and weakness. Conservative treatment had included electrical stimulation, physical therapy, oral medications, chiropractic, and rest without sustained improvement. Symptoms were getting worse and she had new neurologic symptoms. Physical exam documented moderate cervical paraspinal tenderness, limited range of motion due to pain, and positive Spurling's test. Upper extremity motor exam documented 5/5 strength exceed decreased on the in left C7 pattern to 4+/5. Upper extremity sensory exam and deep tendon reflexes were reported intact, except for decreased in left C7 pattern. The patient was worsening with symptoms that interfered with daily activities and work. Records indicated that the patient was off work from 1/14/15 to 1/19/15, and could return to work full duty without limitations on 1/20/15. The treatment plan recommended anterior cervical discectomy and fusion C6/7, as the patient had failed conservative treatment and was worsening. The 1/30/15 utilization review non-certified requests for anterior cervical discectomy, corpectomy, and fusion with instrumentation

at C6/7, and pre-operative clearance with labs, chest x-ray and EKG. The rationale for non-certified was based on evidence that the disc herniation had spontaneously reduced in size with only mild to moderate stenosis, essentially normal neurologic exam, and patient's ability to continue to work without restriction.

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

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

**Anterior cervical discectomy, corpectomy, and fusion with instrumentation at C6-7:**  
Overturned

**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): 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) 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 motor deficit or reflex changes 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 patient presents with neck and left upper extremity pain, numbness and weakness that have worsened over the past year. Signs/symptoms and clinical exam findings are consistent with imaging evidence of a C6/7 disc herniation. There is documentation of a motor deficit that has worsened over the past year. 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 clearance with labs, chest x-ray and electrocardiograph:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Perioperative protocol, Health Care Protocol.

**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.

**Decision rationale:** The California MTUS guidelines do not provide recommendations for pre-operative medical clearance. Evidence based medical guidelines indicate that a basic pre-operative assessment is required for all patients undergoing diagnostic or therapeutic procedures.

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. Routine pre-operative chest radiographs are not recommended except when acute cardiopulmonary disease is suspected on the basis of history and physical examination. An EKG may be indicated for patients with known cardiovascular risk factors or for patients with risk factors identified in the course of a pre-anesthesia evaluation. Although pre-operative clearance with basic lab testing, chest x-ray, and EKG would be supported on the basis of age, magnitude of surgical procedure, recumbent position, fluid exchange and the risks of undergoing anesthesia, the medical necessity of a non-specific request for labs cannot be established. Therefore, this request is not medically necessary.