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| <b>Case Number:</b>   | CM15-0211187 |                              |            |
| <b>Date Assigned:</b> | 10/30/2015   | <b>Date of Injury:</b>       | 06/19/2012 |
| <b>Decision Date:</b> | 12/14/2015   | <b>UR Denial Date:</b>       | 10/19/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 10/27/2015 |

### 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 58-year-old male who sustained an industrial injury on 6/19/12. Records suggested that this was a cumulative trauma injury with remote lifting injury in 1999. Past surgical history was positive for C5-C7 anterior cervical discectomy and fusion in 2011, and right carpal tunnel release with subsequent revision in 2013. Past medical history was positive for hypertension. The 8/15/14 thoracic spine MRI was reported as unremarkable. The 2/26/15 medical legal report documented persistent pain in the neck, arms, legs, hands, lumbar spine, and mid-back with numbness in the arms and legs. Cervical spine exam documented full range of motion. Upper extremity neurologic exam documented 5/5 motor function, no sensory deficits, and brisk and symmetrical deep tendon reflexes. It was noted that he had failed right carpal tunnel release. Additional diagnostic studies were ordered or requested for review. The 3/4/15 medical leg report documented review of the 11/24/14 MRI which showed significant degenerative changes at C4/5 and C5/6 following anterior cervical fusion. There was loss of disc space and osteophyte formation posteriorly with a left sided shoulder at C4/5 and right sided disc herniation at C5/6. Possible surgical intervention was indicated if he continued to have radicular symptoms. The 8/14/15 cervical spine MRI impression documented minor cord indentation at C4/5 and left neuroforaminal stenosis that had slightly progressed since 11/24/14. At C5/6, there was progression of multifactorial changes with more prominent right ventral cord indentation, right lateral recess stenosis, and prominent neuroforaminal stenosis, right greater than left. At C6/7, there was progression of neuroforaminal stenosis which was now moderate to severe bilaterally. Anterior fusion hardware was noted at C5 through C7. The 9/3/15 treating physician

report documented review of the cervical and thoracic MRIs. The cervical study showed significant foraminal narrowing particularly at C5/6 and to a lesser degree at C6/7 on the right. This could account for his right arm radicular complaints. He had some disease on the left with some left-sided symptoms in the same distribution. He complained of numbness in the right thumb and index finger which was progressing and he felt he had a bit more weakness. Physical exam documented no progressive weakness in the right arm, negative Hoffman's, and complaints of some numbness. The treating physician stated that he appeared to have some progressive symptoms predominantly involving the right C6 and C7 nerve roots. Imaging showed significant osteophytes and foraminal compression. He had an anterior surgery and it would be reasonable to consider a posterior decompression at C5 and C6 with bilateral foraminotomies to aggressively decompress the C6 and C7 nerve root with fusion and instrumentation. Authorization was requested for C5/6 decompressive laminectomy with bilateral C5-C7 foraminotomies, and C5-C7 fusion. The 10/19/15 utilization review non-certified the request for C5/6 decompressive laminectomy with bilateral C5-C7 foraminotomies, and C5-C7 fusion as the submitted documentation did not reflect objective evidence of radiculopathy and/or positive Spurling's test, diagnostic findings were not corroborated with clinical findings, and conservative treatment trial and failed was not documented.

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

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

**C5-C6 Decompressive Laminectomy with bilateral C5-C7 Foraminotomies, C5-C7 fusion:**  
Upheld

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

**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, posterior 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 criteria for cervical discectomy. 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. Etiologies of pain such as metabolic sources (diabetes/thyroid disease) non-structural radiculopathies (inflammatory, malignant or motor neuron disease), and/or peripheral sources (carpal tunnel syndrome) should be addressed prior to cervical surgical procedures. Guidelines state that posterior cervical fusion is under study. A posterior fusion and stabilization procedure is often used to treat cervical instability secondary to traumatic injury, rheumatoid arthritis, ankylosing spondylitis, neoplastic disease, infections, and previous laminectomy, and in

cases where there has been insufficient anterior stabilization. Guideline criteria have not been met. This injured worker presents with persistent neck pain radiating into the right upper extremity with numbness in the right thumb and index fingers. He is status post anterior cervical discectomy and fusion at C5/6 and C6/7, and failed right carpal tunnel release and revision. There is no documentation of a positive Spurling's test, motor deficit, reflex change, or positive EMG findings that correlate with the involved cervical level. There is imaging evidence of plausible neural compression at the C4/5, C5/6, and C6/7 levels. There is no evidence that progressive numbness and reported weakness complaints are not related to carpal tunnel syndrome. Detailed evidence of up to 8 weeks of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. Therefore, this request is not medically necessary at this time.