

<b>Case Number:</b>	CM15-0058611		
<b>Date Assigned:</b>	04/03/2015	<b>Date of Injury:</b>	06/14/2011
<b>Decision Date:</b>	06/30/2015	<b>UR Denial Date:</b>	03/03/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/27/2015

### 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:

The injured worker is a 60-year-old female who sustained an industrial injury on 6/14/11, relative to repetitive job tasks as a technician assembler. Past medical history was positive for hypertension, gastritis, asthma, and depression. Past surgical history was positive for left elbow cubital tunnel release in September 2014. The 10/17/14 cervical spine MRI impression documented multilevel disc bulges. At C3/4, there was a 2 mm anterolisthesis of C3 on C4 with no evidence of cord compression or nerve root impingement. At C4/5, there was a 2 mm posterior disc bulge slightly effacing the ventral CSF and approaching the cord. There was no evidence of cord compression or nerve root impingement. At C5/6, there was a 3-4 mm posterior disc bulge with a superimposed 6 x 3 mm left paracentral disc protrusion. There was diminished ventral and dorsal CSF with mild to moderate central canal stenosis. There was moderate foraminal compromise greater on the left with a probability of irritation of the exiting nerve root. There was mild facet hypertrophy present bilaterally. There was a C6/7 level with 2 mm posterior disc bulge and mild facet hypertrophy. There was no cord compression or nerve root impingement detected. The 1/8/15 psychiatric evaluation documented a diagnosis of severe major depressive episode. She did not have suicidal ideation, but an extended period of time when she felt that life was not worth living and she had all the neurovegetative symptoms of a depression that has only partially responded to a relatively high dose of Celexa. Authorization for psychiatric treatment was requested. The 1/12/15 neurosurgical report cited mid-neck pain radiating to the left trapezius into the shoulder, down the arm to the elbow, and occasionally past the elbow and into all the fingers. She reported difficulty working for long periods of time

with her hands, and occasionally dropped things from both hands. Physical exam documented 4+/5 left upper extremity weakness in the deltoid, triceps, biceps, hand grip, and intrinsics. Right upper extremity strength was 5/5. Sensation was reported decreased by approximately 50% of normal below the elbow. There was no evidence of hyperreflexia. She had moderate discomfort with cervical motions and lower cervical spine tenderness. MRI findings documented slight anterolisthesis of C3 on C4/5 with a small disc bulge. There was a small disc bulge also at C4/5. At C5/6, there was a posterior disc protrusion with mild to moderate canal stenosis, foraminal compromise, left greater than right, with irritation of the exiting nerve root. The treatment plan recommended cervical epidural steroid injections. The 2/24/15 treating physician report cited increasing neck pain radiating into the left upper extremity as before. She had 4+/5 lower extremity upper extremity weakness. She reported her pain was getting worse and wanted to procedure with surgery rather than epidural steroid injection. Physical exam documented global left upper extremity weakness, decreased sensation below the elbow and intact reflexes. Authorization was requested for anterior cervical discectomy and fusion at C5/6 with plate. The 3/30/15 utilization review non-certified the request for anterior cervical discectomy and fusion at C5/6 with plate as there was insufficient evidence to correlate the symptoms with a left C6 radiculopathy. There was no documentation of electrodiagnostic study findings or discussion of the potential for residual ulnar neuropathy.

### **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 at C5-C6 with plate:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck & Upper Back, Fusion, anterior cervical.

**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) 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. 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 not been met.

This injured worker presents with neck pain radiating down the left upper extremity to the fingers. There was no evidence of a positive Spurling's test. There was no evidence of a focal motor or sensory deficit correlated with imaging evidence of plausible C5/6 nerve root compression. There was no documentation of electrodiagnostic or selective nerve root block findings consistent with nerve root compression at the C5/6 level. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. Additionally, there was potential significant psychological issues with no evidence of psychological clearance for surgery. Therefore, this request is not medically necessary.