

<b>Case Number:</b>	CM15-0082302		
<b>Date Assigned:</b>	05/04/2015	<b>Date of Injury:</b>	08/17/2011
<b>Decision Date:</b>	06/03/2015	<b>UR Denial Date:</b>	03/27/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/29/2015

### 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 8/17/11. Injury occurred while she was lifting heavy totes. Past surgical history was positive for left carpal tunnel release in February 2013, and right total shoulder arthroplasty on 11/4/14. She underwent a C6/7 epidural steroid injection on 10/29/13 with no relief. The 8/18/14 electrodiagnostic study was reported as abnormal with findings suggestive of probable left C5/6 radiculopathy. The 1/12/15 cervical spine MRI impression documented segmental stenosis of C4/5, C5/6, and C6/7. Bilateral foraminal encroachment was most prominent at C5/6 and C6/7, with right greater than left foraminal encroachment at C4/5. At C4/5, there was moderate intervertebral disc narrowing and circumferential osteophyte formation. There was a superimposed broad-based disc bulge, most pronounced in the right paracentral region where there was significant mass effect on the ventral aspect of the cord. This resulted in moderate segmental stenosis. There was right greater than left foraminal narrowing secondary to uncovertebral joint degeneration. At C5/6, there was a prominent left-sided disc herniation at C5/6 superimposed upon significant osteophytic ridge formation, with moderate to severe segmental stenosis and significant mass effect upon the left anterolateral aspect of the thecal sac. There was mild to moderate right foraminal encroachment and moderate to severe left foraminal encroachment. At C6/7, there was intervertebral disc narrowing and mild segmental narrowing of the canal with moderate bilateral foraminal encroachment. The 3/17/15 treating physician report cited continued grade 6/10 neck pain radiating to the left upper extremity. The injured worker was reported as a current smoker. MRI findings were documented. Physical exam documented she stood erect and ambulated without

difficulty. No neurologic exam was documented. The treatment plan requested C4/5, C5/6, and C6/7 anterior cervical discectomy and fusion. The 3/25/15 pain management report cited neck pain radiating to the occipital area and down the left arm to the fingers with tingling. Pain was normally 9/10 and decreased to 5/10 with pain medications. She reported that she was dropping things with the left hand. Physical exam documented severe left cervical paravertebral and trapezius muscle tenderness, restricted left rotation and tilt, negative cervical compression test, and negative Spurling's test. Left shoulder exam documented acromioclavicular joint tenderness, restricted and painful range of motion beyond 90 degrees, and positive Neer and Hawkins's tests. Left elbow exam documented lateral epicondyle tenderness, full and painless range of motion, and no instability or provocative testing. Left wrist exam documented volar tenderness, full range of motion, and positive Tinel's sign. There was no neurologic examination documented. The pain management physician concurred with the request for cervical spine surgery. Medications were refilled. The 3/27/15 utilization review non-certified the request for anterior cervical discectomy and fusion C4/5, C5/6, and C6/7 with spacer, allograft and plating, and inpatient stay for 2 days as there were no clinical exam findings consistent with neurologic deficit and there was no detailed conservative treatment.

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

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

**Allograft and plating:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 179-181.

**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, Plate fixation, cervical spine surgery.

**Decision rationale:** As the anterior cervical discectomy and fusion request is not supported, this request is not medically necessary.

**Associated surgical services: In-patient stay for 2 days:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment Index 11th Edition (web) 2013 Neck & Upper Back, Hospital length of stay.

**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:** As the surgical request is not supported, this request is not medically necessary.

**Anterior Cervical Discectomy and fusion at C4-C5, C5-C6, C6-C7 with spacer:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment Index 11th Edition (web) 2013 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) 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 not been met. This injured worker presents with neck pain radiating to the left upper extremity. There is imaging evidence of multilevel stenosis and plausible neurocompression, and EMG findings suggestive of probable left C5/6 radiculopathy. Spurling's test was negative. There is no clinical exam evidence of motor deficit or reflex changes correlated with the imaging study. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. Additionally, the injured worker is noted to be a current smoker with no discussion of smoking cessation. Therefore, this request is not medically necessary at this time.