

<b>Case Number:</b>	CM15-0083112		
<b>Date Assigned:</b>	05/08/2015	<b>Date of Injury:</b>	11/14/2011
<b>Decision Date:</b>	06/18/2015	<b>UR Denial Date:</b>	04/02/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/30/2015

### 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 64-year-old female who sustained an industrial injury on 11/14/11. Injury occurred when a student kicked a basketball and it hit the right side of her head behind her ear. The 1/2/15 cervical x-rays impression documented degenerative disc disease with abnormal alignment. There was marked narrowing of the intervertebral disc spaces from C2 through C7 with significant sclerosis and irregularity along the endplates. There were large ventral osteophytes from C3 through C5 that did not significantly encroach upon the AP diameter of the bony canal. The injured worker had a swan neck deformity with reversal of the normal cervical lordosis in the upper cervical spine with slight extension at the C1/2 level. With flexion, the atlantoaxial interval was 2 mm. This decreased to 0 with extension and in neutral. The 1/2/15 cervical spine MRI impression documented re-demonstration of cervical spondylosis at multiple levels with reversal of the normal lordosis. Spinal stenosis at C3/4 was slightly more progressed due to more prominence of the right paracentral disc spur complex causing cord compression without myelomalacia. Other degenerative changes remained stable. Findings documented a broad-based disc osteophyte complex at C4/5 with more prominent right paracentral component measuring 3 mm causing mild spinal stenosis without cord compression. There was mild left and moderate right foraminal stenosis due to uncovertebral joint arthropathy. At C5/6, there was disc space narrowing with endplate irregularity and degenerative changes. There was a disc osteophyte complex with more prominent paracentral component measuring 2 to 3 mm causing mild spinal stenosis without cord compression and mild bilateral foraminal narrowing. At C6/7, there was disc space narrowing with endplate irregularity and degenerative signal with 2 to 3 mm

posterior disc osteophyte complex causing mild spinal stenosis without cord compression. Facet and uncovertebral joint arthropathy caused mild to moderate bilateral foraminal narrowing. The 1/8/15 spine surgery report cited complaints of neck pain radiating to the right arm, forearm, and hand. Associated symptoms included balance issues, problems dropping objects from the right dominant hand, and handwriting deterioration as she dropped pens when she wrote. She had done physical therapy and acupuncture. Physical exam documented 3 beat clonus on the right side with positive Hoffman's sign right hand. Cervical range of motion was decreased 30-50% in flexion, extension, and rotation. Motor testing documented 4/5 left deltoid, 4/5 left biceps, 4-/5 right deltoid, 4-/5 right biceps, 4/5 right wrist extensor, and 3/5 right triceps weakness. Deep tendon reflexes were reported 3/4 bilateral biceps, 3/4 left triceps, 1/4 right triceps, 2/4 left brachioradialis, 0/4 right brachioradialis, 3/4 bilateral patella, and 2/4 bilateral Achilles. Sensory testing was diminished over the lower arm and right first dorsal web space on the right. Imaging showed C3/4 large right sided disc herniation with severe stenosis and 5-6 mm canal diameter with early signal change in the spinal cord behind the C4 vertebral body. There were C4/5, C5/6, and C5/6 disc herniations with foraminal stenosis, right worse than left. X-rays showed severe spondylosis with collapse of disc spaces C3-C7 with kyphotic deformity noted. She had clinically progressive myelopathy and radiculopathy, involving right upper extremity motor deficits, dexterity and gait/balance deterioration. MRI confirmed multilevel spondylosis and stenosis with loss of cervical lordosis and kyphotic deformity spanning C3-C7. Motor deficits correlated with MRI and radiographic abnormalities. She had failed conservative treatment with physical therapy and acupuncture. Due to gait instability, reflex changes, clonus and presence of Hoffman's sign, surgical intervention was recommended to include C3-7 anterior discectomy and instrumented arthrodesis, and possible C4 corpectomy to decompress her most stenotic segment. The 4/2/15 utilization review non-certified the request for C3-7 anterior discectomy and instrumented arthrodesis and possible C4 corpectomy as there was no clear evidence to support the request for extensive fusion including C4/5, C5/6, and C6/7.

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

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

**C3-C7 anterior discectomy and instrumented arthrodesis, possible C4 corpectomy to decompress her most stenotic segment:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 180. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back Chapter.

**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. Guideline criteria have been met. This injured worker presents with persistent neck pain radiating to the right upper extremity with significant weakness. Clinical exam findings are consistent with imaging evidence of cord compression and severe spondylosis and disc space collapse from C3-C7. 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.