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| <b>Case Number:</b>   | CM15-0083985 |                              |            |
| <b>Date Assigned:</b> | 05/06/2015   | <b>Date of Injury:</b>       | 01/25/2013 |
| <b>Decision Date:</b> | 06/05/2015   | <b>UR Denial Date:</b>       | 04/15/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 05/01/2015 |

### 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 male who sustained an industrial injury on 1/25/13, relative to a motor vehicle accident. Past medical history was positive for cardiac and prostate issues, and significant emotional distress. Social history was positive for current someday smoking. Conservative treatment included medications, activity modification, and physical therapy. The 11/5/13 cervical spine MRI revealed cervical spondylosis with central stenosis at C5/6 and C6/7, and foraminal stenosis at both levels. The 3/31/14 treating physician report documented neck and arm pain with biceps and triceps weakness, decreased C6 and C7 dermatomal sensation, and depressed upper extremity reflexes. Failure of conservative treatment was documented. Anterior cervical discectomy and fusion (ACDF) was requested at C5/6 and C6/7. The 4/22/14 utilization review certified this request as meeting applicable guidelines. Records indicated that his wife was disabled and he was the primary caregiver. The 3/2/15 treating physician report cited a chief complaint of axial neck pain. Prior authorization for C5-7 anterior cervical discectomy and fusion was reported with surgery delayed for cardiac clearance and a pending prostate biopsy for an elevated PSA. Cervical spine exam documented normal range of motion with negative Spurling's. There was right grip strength and 4+/5 biceps weakness, and right C6 and C7 hypesthesia. The diagnosis was cervical spondylotic stenosis, most remarkable at C5/6 and C6/7. Re-authorization for ACDF C5-7 was requested. The 4/15/15 utilization review non-certified the request for anterior cervical discectomy and fusion at C5-7 as there was no imaging evidence of nerve root compression and no psychological evaluation.

## 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 C5-7: Upheld**

**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 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 not been met. This patient presents with axial neck pain that has reportedly failed reasonable and comprehensive conservative treatment. There is current clinical exam evidence of motor deficit and sensory loss consistent with reported imaging evidence of spinal stenosis at the C5/6 and C6/7 levels. However, there is a documented smoking history with no current discussion of smoking cessation. Additionally, potential psychological issues are noted and there is no evidence of a psychological clearance for surgery. Therefore, this request is not medically necessary at this time.