

Case Number:	CM15-0085423		
Date Assigned:	05/07/2015	Date of Injury:	11/26/2012
Decision Date:	06/09/2015	UR Denial Date:	04/25/2015
Priority:	Standard	Application Received:	05/04/2015

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 65-year-old male who sustained an industrial injury on 11/26/12. Injury occurred when he was changing an electrical cable and lost his balance, falling onto his right side. Past surgical history was positive for a right shoulder arthroscopic subacromial decompression on 6/24/14. The 1/05/15 treating physician report cited continued neck pain radiating to both upper extremities. Clinical exam findings were reported consistent with C6 and C7 radiculopathy. A repeat MRI was requested to assess disc protrusions at C5/6 and C6/7 previously identified, and in anticipation of a C5-7 fusion. The 1/21/15 cervical spine MRI impression documented a diffuse posterior disc bulge at C5/6 with a left paracentral component and impingement of the emerging left nerve in the left lateral recess. There was partial loss of the anterior CSF space with mild to moderate canal narrowing and mild bilateral neuroforaminal narrowing. At C6/7, there was a 3 mm far left lateral disc osteophyte complex, which extended into the left neural foramen with probable impingement of the exiting nerve root. There was loss of disc signal and partial loss of disc height, mild anterior disc bulge, mild right neuroforaminal narrowing and partial loss of the anterior CSF space with mild spinal canal narrowing. The MRI addendum documented a 4-5 mm central disc protrusion at C5/6, more to the left, impinging on the anterior aspect of the cervical cord with loss of anterior CSF space. The cord at the C5/6 level measured 5.2 mm in AP dimension compared to the cord at the mid-C5 and mid-C6 levels that measured 6.1 mm in AP dimension. There was no abnormal cord signal noted at the level of C5/6. There was mild right and mild to moderate left foraminal narrowing. The 4/25/15 utilization review non-certified the request for anterior cervical discectomy and fusion (ACDF)

C5-C7 as there were no clinical exam or positive EMG findings that would indicate the presence of cervical radiculopathy, and MRI findings did not correspond to symptoms. The 5/4/15 treating physician report cited significant neck pain radiating into both upper extremities, left greater than right. Cervical spine exam documented moderate loss of range of motion, and sensation decreased in the right thumb, index, and some in the ring finger. Motor exam documented 5-/5 bilateral biceps weakness, and 5-/5 right triceps and wrist extensor weakness. Deep tendon reflexes were symmetrical bilaterally. Clonus was absent. The treating physician appealed the denial of the ACDF. He stated that the patient had pain radiating into both upper extremities, left greater than right. He had left C6 weakness and right C6 and C7 weakness, and decreased right upper extremity sensation in a C6 and C7 distribution. The MRI confirmed a C5/6 disc protrusion more to the left impinging on the cervical cord with loss of anterior CSF space and cord narrowing to 5.2 mm versus 6.1 at the adjacent level. There was mild right and mild to moderate left foraminal narrowing at C5/6. At C6/7, there was a left lateral disc osteophyte complex causing foraminal stenosis and probable nerve root impingement. There was radiographic evidence of C5/6 and C6/7 spondylosis. The injured worker had failed conservative treatment, including 3 epidural steroid injections. He had clear radiculopathy and arm pain on the left greater than right, C6 and C7 weakness in bilateral upper extremities, and C6 and C7 numbness in the right upper extremity with some cord deflection and narrowing noted on the MRI and spondylosis from C5-C7 noted on the x-rays. Authorization was requested for C5-7 ACDF.

IMR ISSUES, DECISIONS AND RATIONALES

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

Anterior Cervical spine Discectomy/Fusion C5-C7: Overturned

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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. Guideline criteria have been met. This injured worker presents with persistent neck pain radiating into both upper extremities, left greater than right, and sensory symptoms consistent with a C6 and C7 distribution. Clinical exam documented motor deficits consistent

with imaging evidence of cord impingement at C5/6 and plausible nerve root compression at C6/7. 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.