

<b>Case Number:</b>	CM15-0088766		
<b>Date Assigned:</b>	05/13/2015	<b>Date of Injury:</b>	02/23/2010
<b>Decision Date:</b>	06/12/2015	<b>UR Denial Date:</b>	05/02/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/08/2015

### 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:

This injured worker is a 49-year-old male who sustained an industrial injury on 2/23/10. Injury occurred when he was trimming a tree and was struck on the top of the head by a falling branch. Past medical history was positive for insulin dependent diabetes. The 8/29/11 bilateral upper extremity electrodiagnostic study impression documented mild bilateral carpal tunnel syndrome. The 10/11/13 left upper extremity electrodiagnostic study was reported normal. The 1/14/15 cervical spine MRI impression was documented in the treating physician reports and showed a mild posterior disc bulge at C4/5. At C5/6, there was a broad, posterior disc bulge, narrowing the canal diameter to approximately 8 mm with an imprint on the anterior margin of the cord without gross cord compression. At C6/7, there was a 1-2 mm broad-based posterior disc bulge indenting the anterior canal. At C7/T1, there was an additional posterior disc protrusion. The 4/16/15 treating physician report cited continued chronic neck pain at the base of his neck, more on the left than the right. He also reported chronic mid back and low back pain radiating into both legs, left greater than right. Imaging on 1/14/15 revealed multilevel cervical spondylosis, degenerative disc disease and posterior disc bulges. The neurosurgeon had recommended a one level anterior cervical discectomy and fusion (ACDF) at C5 and C6. Cervical spine exam documented left paravertebral and trapezius muscle spasms and tenderness, and limited cervical range of motion with left sided discomfort. Neurologic exam documented intact motor and sensation to both the upper and lower extremities. Upper and lower deep tendon reflexes were reported trace and symmetrical. The diagnosis included cervicgia, multilevel cervical degenerative disc disease and spondylosis, and chronic pain syndrome. The treatment plan recommended ACDF at C5/6

per the neurosurgeon. The 5/2/15 utilization review non-certified the request for C5/6 anterior cervical discectomy and fusion and associated bone graft based on a failure to meet guidelines relative to clinical exam findings and lack of evidence of instability.

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

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

#### **One level anterior cervical discectomy and fusion (ACDF) at C5/6: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 166. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back (Acute & Chronic): Fusion, anterior cervical (2014).

**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 chronic neck pain at the base of his neck. There is no documentation of radicular symptoms or positive Spurling's test. There is no clinical exam evidence of motor deficit or reflex changes, or positive EMG findings. Additionally, there is no documentation of a positive selective nerve root block. There is imaging evidence of a broad posterior disc protrusion at C5/6 that imprints the cord, but there was no evidence of cord compression. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. The neurosurgical reports have not been submitted for review. Therefore, this request is not medically necessary.

**Bone graft:** Upheld

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

**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: Fusion, anterior cervical.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.