

<b>Case Number:</b>	CM15-0089329		
<b>Date Assigned:</b>	05/14/2015	<b>Date of Injury:</b>	07/27/2010
<b>Decision Date:</b>	06/16/2015	<b>UR Denial Date:</b>	04/13/2015
<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:

The injured worker is a 55-year-old male who sustained an industrial injury on 7/27/10, relative to cumulative trauma as a steam fitter. The 1/17/15 cervical spine MRI findings documented C3/4 disc desiccation and moderate loss of disc space height. There was a 2 mm retrolisthesis in conjunction with 2 mm posterior broad-based disc bulge resulting in effacement of the thecal sac and abutment of the ventral central cord. There was ligamentum flavum hypertrophy resulting in dorsal effacement of the thecal sac and abutment of the dorsal margin of the cervical cord. There was mild to moderate central canal stenosis. The disc and uncovertebral joint arthropathy resulted in severe bilateral neuroforaminal stenosis and impingement of the bilateral foraminal C4 nerves. At C6/7, there was moderate loss of disc space height, moderate disc desiccation and 2-3 mm posterior broad-based disc protrusion effacing the ventral thecal sac and abutting the ventral cervical cord. There was left facet arthropathy with a hypertrophic osteophyte protruding into the left lateral recess and resulting in severe lateral recess stenosis and impingement on the ventral and dorsal C7 nerve roots. There was abutment and minimal effacement of the left lateral spinal cord. The 1/24/15 electrodiagnostic study impression documented no evidence of cervical radiculopathy as there was no evidence of denervation or reinnervation potentials. There was evidence for generalized peripheral polyneuropathy affecting both motor and sensory nerves. In this setting, an active radiculopathy was not excluded. The 3/19/15 treating physician report cited grade 5/10 neck pain radiating to the upper and lower back. Physical exam documented that the injured worker was able to toe walk, heel walk and squat without too much difficulty. The neck showed no listing with increased pain especially turning to the right. There was decreased

sensation in the left C7 dermatome, 5/5 motor function throughout, and 2+ and symmetrical deep tendon reflexes. Cervical spine x-rays showed retrolisthesis of C3 on C4 with foraminal narrowing at C3/4. Flexion/extension views showed instability in flexion/extension at the C3/4 level. The 4/13/15 utilization review partially certified the request for anterior cervical discectomy and fusion at C6-7, and anterior cervical corpectomy and fusion at C3-4 to anterior cervical discectomy and fusion at C6/7 with a one-day inpatient hospital stay. The rationale stated that the submitted documents did not reflect clinical signs or symptoms compatible with neuropathy at the C3/4 level.

### **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 C6-7, anterior cervical corpectomy and fusion at C3-4:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**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. Cervical fusion is supported for demonstrated spinal segmental instability. Guideline criteria have been met. This patient presents with persistent cervical pain and functional limitations. Clinical exam findings were consistent with imaging evidence of C7 nerve root compression. Additionally, there is imaging evidence of spondylolisthesis at C3/4 with demonstrated instability on flexion/extension x-rays and impingement of the bilateral C4 nerve roots. Evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. The 4/13/15 utilization review partially certified this request for anterior cervical discectomy and fusion at C6/7. Given the instability and imaging findings documented at the C3/4 level, this request, including anterior cervical corpectomy and fusion, is appropriate. Therefore, this request is medically necessary.

**Associated service: two day inpatient stay:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**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:** The California MTUS does not provide hospital length of stay recommendations. The Official Disability Guidelines recommend the median length of stay (LOS) based on type of surgery, or best practice target LOS for cases with no complications. The recommended median and best practice target for anterior cervical fusion is 1 day. The 4/13/15 utilization review modified the request for 2 days length of stay, certifying 1 day. Given the surgical intervention at two, non-contiguous cervical levels, a 2-day length of stay would be reasonable. Therefore, this request is medically necessary.