

<b>Case Number:</b>	CM14-0162296		
<b>Date Assigned:</b>	10/07/2014	<b>Date of Injury:</b>	10/24/2013
<b>Decision Date:</b>	11/07/2014	<b>UR Denial Date:</b>	09/30/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/02/2014

### 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. The expert reviewer is Board Certified in Orthopedic Spine Surgeon and is licensed to practice in Texas. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 49-year-old female who reported an injury on 10/24/2013. The mechanism of injury was a slip and fall in the ladies restroom. Prior treatments included massage and acupuncture. The injured worker underwent physical therapy. The injured worker underwent a magnetic resonance imaging (MRI) of the cervical spine on 05/07/2014 which revealed at the level of C6-7 there was a 3 mm broad based disc bulge effacing the central CSF space resulting in canal stenosis and mass effect upon the ventral aspect of the cervical cord with mild flattening of the cord. There was no associated neural foraminal compromise. The documentation of 06/23/2014 revealed the injured worker had axial neck pain representing 70% of her symptoms. The surgical history revealed no cervical spine surgery. The physical examination revealed cervical alignment was normal. The injured worker had normal range of motion in flexion, extension, axial rotation, and bilateral lateral bending. The motor strength testing revealed weakness of the biceps on the right at 4/5 as compared to the left, otherwise noted to be intact. Sensation was diminished to pinprick and light touch in the left upper extremity. The Hoffmann's reflex was positive bilaterally. Spurling's test was negative. Carpal and cubital tunnel testing was negative bilaterally. The injured worker underwent x-rays of the cervical spine revealing ossification of the annulus at C5-6 and C6-7 with a reasonably well maintained disc height. The diagnosis included spinal stenosis in the cervical region, brachial neuritis and radiculitis, other. The treatment plan included a C5-6, C6-7 anterior cervical discectomy and fusion. The official x-ray report for 06/23/2014 revealed the injured worker had mild torticollis and minimal cervical spondylosis with nothing acute. The injured worker underwent electromyography on 07/30/2014 which revealed the electrodiagnostic study was within normal limits. There was no electrodiagnostic evidence of radiculopathy on the right upper extremity. The injured worker had difficulty with the needle portion of the rest of the test

and did not proceed with the needle study on the left side. The documentation of 09/15/2014 revealed the injured worker had neck pain, right shoulder pain, and numbness of the right hand and had low back pain. The injured worker was noted to have a short course of physical therapy, massage therapy, and pool therapy. The physician documented the injured worker had an EMG and nerve conduction study that was unremarkable. The injured worker's current complaints were noted to include pain radiating to the right shoulder. The injured worker had a constant pain in the cervical region with an occasional cracking sensation with cervical rotation. The physical examination revealed the injured worker had decreased cervical rotation and flexion. The injured worker tolerated cervical compression and distraction without reproduction of symptoms. The injured worker underwent x-rays on the date of examination which revealed degeneration at C5-6 and C6-7 with anterior and posterior endplate lipping and disc space narrowing. There was localized kyphosis. The diagnosis included C6-7 degenerative spondylosis with central spinal canal stenosis without cervical radiculitis. The treatment plan included a C6-7 anterior discectomy, fusion, and instrumentation. The injured worker had 1 beat of ankle clonus bilaterally and had decreased sensation at the right C6 dermatome. The injured worker's medications included Ultracet 37.5/325 mg 1 by mouth as needed, Motrin 800 mg by mouth as needed, Zanaflex 4 mg by mouth at bedtime and trazodone 50 mg by mouth at bedtime. There was no Request for Authorization submitted for the requested procedure.

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

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

**Anterior C6-C7 discectomy, using allograft and anterior instrumentation w/locking plate**  
**Qty: 1.00:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 179-180. 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 rationale:** The American College of Occupational and Environmental Medicine indicates that a surgical consultation may be appropriate for patients who have activity limitation for more than 1 month or with extreme progression of symptoms. There should be documentation of clear clinical, imaging, and electrophysiological evidence consistently indicating the same lesion that has been shown to benefit from surgical repair in both the short and long term. There should be documentation of unresolved radicular symptoms after receiving conservative treatment. The clinical documentation submitted for review indicated the injured worker had objective clinical findings. The MRI revealed the injured worker had a 2 mm left paracentral disc protrusion effacing the ventral CSF space and contacting the ventral aspect of the cervical cord, flattening it slightly. The MRI failed to provide documentation of nerve impingement. There was a lack of documentation of electrophysiologic evidence to support the necessity for surgical intervention. Given the above, the request for anterior C6-7 discectomy using allograft and anterior instrumentation with locking plate, quantity: 1 is not medically necessary.

**Assistant surgeon (PA) Qty: 1.00:** Upheld

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

**Inpatient hospital stay per day Qty: 2.00:** Upheld

**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:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 179-181.

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