

<b>Case Number:</b>	CM15-0170809		
<b>Date Assigned:</b>	09/11/2015	<b>Date of Injury:</b>	05/30/2015
<b>Decision Date:</b>	10/13/2015	<b>UR Denial Date:</b>	08/21/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/31/2015

### 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 56-year-old female who sustained an industrial injury on 5/30/15. Injury occurred while she was working as an RN Charge Nurse in ICU and was assaulted in the head and chest by a combative patient. Past surgical history was positive for C5-C7 anterior cervical discectomy and fusion in 1997. Conservative treatment included cervical collar, rest, oral steroids, anti-inflammatory medications, muscle relaxant medications, massage therapy, gentle exercise, and activity modification. The 6/10/15 cervical spine MRI impression documented incomplete interbody fusion at the C6/7 level with bony fusion only seen along the right side of the disc space. There was body irregularity and Modic type 2 signal changes within the endplates surrounding the C5/6 disc space. There was no evidence for anterior or interbody fusion at the C5/6 level. There was a right paramedian disc protrusion at C5/6 resulting in severe right-sided central canal stenosis and right neuroforaminal stenosis. There was severe mass effect upon the right side of the cervical cord at this level with no signal changes to suggest myelopathy. There was moderate degenerative disc disease and facet disease with severe left neuroforaminal stenosis. At C4/5, there was mild to moderate degenerative disc and facet disease resulting in moderate bilateral neuroforaminal narrowing. There was partial bony fusion of the C6 and C7 disc space, with moderate facet hypertrophy resulting in mild bilateral neuroforaminal narrowing. The 7/9/15 treating physician report cited neck pain radiating into the arms with numbness and tingling for 2 months. She was status post prior C5-7 anterior cervical discectomy and fusion. Imaging showed non-fusion and a persistent disc at C5/6 with moderate right sided disc bulge and mild to moderate spinal stenosis and neuroforaminal stenosis. She had been wearing a cervical collar in the extension position and was feeling worse.

She was not working. Physical exam documented normal tandem gait and decreased cervical range of motion. Neurologic exam documented normal muscle power and tone, hyperactive bilateral deep tendon reflexes, positive finger flexors but no clonus or Babinski, and numbness and tingling in the thumb and index fingers bilaterally. The diagnosis included recurrent bilateral cervical radicular myelopathy in a patient with C6/7 and reportedly C5/6 anterior cervical discectomy and fusion with no clearly obvious fusion at C5/6 with significant right-sided osteophyte. The treatment plan included cervical collar, Medrol Dosepak, and Voltaren. A cervical spine CT scan and cervical flexion/extension films were recommended. The 7/23/15 cervical spine CT scan impression documented severe degenerative disc narrowing and facet disease at C5/6. There were prominent posterior osteophytes resulting in severe right paramedian central canal stenosis and right neuroforaminal narrowing, and moderate left bony neuroforaminal narrowing. There were degenerative changes at the C4/5 and C6/7 levels with mild bilateral bony neuroforaminal narrowing. There was partial fusion of the C6/7 disc space, with unfused left lateral component. The 8/13/15 treating physician report cited significant neck pain radiating down her right arm consistent with right C6 radiculitis. CT scan confirmed the fusion at C6/7 but probable non-fusion at the C5/6 level with significant right C6 osteophyte and marked right C5/6 neuroforaminal encroachment. Authorization was requested for redo of C5-6 anterior cervical discectomy and fusion, spinal cord decompression and C6 nerve root decompression, and associated inpatient stay. The 8/21/15 utilization review non-certified the request for redo of C5-6 anterior cervical discectomy, fusion, spinal cord decompression and C6 nerve root decompression with inpatient stay. The rationale stated that there was a possible pseudoarthrosis at the C5/6 level but localizing the pain to that level had not been confirmed by a selective nerve root block. The 9/16/15 treating physician appeal indicated that the injured worker had persistent pain, numbness and tingling down her arm with some mild weakness today. Review of her films showed marked C5/6 osteophyte, clearly non-fusion, and pseudoarthrosis at C5/6 with marked right C5/6 neuroforaminal encroachment. There was no other treatment other than to decompress her C6 nerve root and re-do the C5/6 anterior cervical discectomy and fusion. The 9/17/15 injured worker appeal letter stated that she had on-going neck, head, and scapular pain with persistent numbness in her right arm, thumb and index finger. She had difficulty writing with a pen, and on-going paresthesia and numbness of the entire right arm. She was unable to flex her head without neck spasms and pain. She had numbness of the right thumb upon waking in the morning that was taking longer and longer to return during the day. These symptoms were progressively increasing despite conservative treatment. She restated the 6/10/15 MRI findings at the C5/6 level. Appeal of the denial of surgery was requested.

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

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

**Redo C5-C6 Anterior Cervical Discectomy, Fusion, Spinal Cord Decompression, C6 Nerve Root Decompression:** 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), Neck and Upper Back (Acute & Chronic) - Fusion, anterior cervical.

**MAXIMUS guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Surgical Considerations. 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. The ODG state that pseudoarthrosis is recognized as an etiology of continued cervical pain and unsatisfactory outcome. Treatment options include a revision anterior approach vs. a posterior approach. Regardless of approach, there is a high rate of continued moderate to severe pain even after solid fusion is achieved. Guideline criteria have been met. This injured worker presents with worsening neck pain radiating into the right upper extremity with numbness, tingling, and weakness in the C6 distribution. Functional limitations have precluded return to work. Clinical exam findings are consistent with imaging evidence of neural compression at the C5/6 level and plausible pseudoarthrosis. 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.

**Associated surgical service: Inpatient Stay:** 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), Neck and Upper Back (Acute & Chronic) - Fusion, anterior cervical.

**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 discectomy and fusion is one day. An inpatient stay following the requested surgery would be supported for up to 1 day. However, the medical necessity of a non-specific request cannot be established. Therefore, this request is not medically necessary.

