

<b>Case Number:</b>	CM15-0176625		
<b>Date Assigned:</b>	09/17/2015	<b>Date of Injury:</b>	06/17/2014
<b>Decision Date:</b>	10/20/2015	<b>UR Denial Date:</b>	08/07/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/08/2015

### 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 51-year-old female who sustained an industrial injury on 6/17/14, Injury occurred when she slipped and fell, hitting her head against a desk and landing on the ground. The 11/17/14 electrodiagnostic findings revealed mild left ulnar neuropathy at the elbow with findings suspicious for possible mild left C7 radiculopathy. Conservative treatment included activity modification, medications, physical therapy, and cervical epidural steroid injections. The 6/11/15 spine surgery report indicated that the injured worker underwent a cervical epidural steroid injection since the last visit with excellent improvement in her symptoms for 3 days, followed by gradual return. She reported good and bad days. On the bad days, she had severe neck pain radiating all the way down the right arm to her hand with associated numbness and tingling. She had left shoulder and elbow discomfort with numbness into the 4th and 5th digits. Neurologic exam documented intact motor function and decreased sensation in the left 4th and 5th digits. Cervical range of motion was moderately restricted in all planes with end-range pain and tenderness to palpation over the left trapezius. The diagnosis included cervical strain, cervical spondylosis C4/5, C5/6 and C6/7, left cubital tunnel syndrome, and mild C7 radiculopathy. The injured worker remained symptomatic despite conservative treatment. Her symptoms were consistent with MRI findings of severe left C5/6 foraminal stenosis and moderate left C6/7 foraminal stenosis, as well as significant spondylosis at C4/5. The treatment plan recommended surgery to include anterior cervical discectomy and fusion of C5/6 and arthroplasty of C4/5 and C6/7. The 6/26/15 treating physician report indicated the injured worker was being followed for left cubital tunnel syndrome. She was using a nighttime extension brace, elbow pads, and was going to physical therapy with no improvement.

There was significant left medial elbow pain with use and persistent numbness and tingling in the 4th and 5th fingers. Physical exam documented positive Tinel's over the cubital tunnel with a positive elbow flexion test. There was slight tenderness over the ulnar nerve with no subluxation. There was no evidence of intrinsic weakness or atrophy. The treatment plan recommended continued physical therapy and conservative treatment for 6 months per guidelines prior to surgery. The 7/14/15 cervical spine MRI impression documented a 4-5 mm diffuse annular bulge at C5/6 with diffuse osteophyte ridging which moderately compressed the cord and moderately narrowed the canal. There was bilateral uncinete hypertrophy with severe left neuroforaminal narrowing in combination with facet hypertrophy and moderate to severe right neuroforaminal narrowing. At C6/7, there was a 3 mm disc osteophyte complex and facet hypertrophy with mild to moderate neuroforaminal narrowing. At C4/5, there was mild to moderate bilateral right foraminal stenosis and uncinete facet hypertrophy. AT C3/4, there was mild to moderate left foraminal stenosis and facet hypertrophy. At C2/3, there was left facet hypertrophy with moderate left neuroforaminal narrowing. Authorization was requested for anterior cervical discectomy and fusion at C5/6 and disc replacement at C4/5 and C6/7 with associated surgical requests for 2 day inpatient stay and Vista cervical collar. The 8/7/15 utilization review non-certified the anterior cervical discectomy and fusion at C5/6 and disc replacement at C4/5 and C6/7 with associated requests. The rationale indicated that it was unclear whether the ulnar neuropathy had been addressed prior to surgical consideration and artificial disc replacement was not indicated in patients with degenerative disc disease at multiple levels.

### **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 C5-6, disc replacement C4-5 and C6-7: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back Chapter.

**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; Disc prosthesis.

**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. The Official Disability Guidelines indicate that disc prostheses are under study. While comparative studies with anterior cervical fusion yield similar results, the expectation of a decrease in adjacent segment disease development in long-term studies remains in question. And there is an additional problem with the long-term implications of development of heterotopic ossification. Additional studies are required to allow for a "recommended" status.

The general indications for currently approved cervical-ADR devices (based on protocols of randomized-controlled trials) are for patients with intractable symptomatic single-level cervical DDD who have failed at least six weeks of non-operative treatment and present with arm pain and functional/ neurological deficit. Guideline criteria have not been met. This injured worker presents with severe neck pain radiating down the right arm to her hand with associated numbness and tingling. She has signs/symptoms, clinical exam findings, and electrodiagnostic evidence of left cubital tunnel syndrome. There is imaging evidence of severe left C5/6 and moderate left C6/7 and spondylosis at C5/6. Conservative treatment for the cervical spine has included medications and epidural steroid injection. However, guidelines do not support the use of cervical artificial disc replacement in patients with multilevel degenerative disc disease and peer-review literature only supports 2 level artificial disc replacement at contiguous levels. The request for a hybrid construct, artificial disc replacements and fusion, lacks long term large volume literature studies. Therefore, this request is not medically necessary.

**Associated surgical service: 2 day 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, Neck & Upper Back Chapter, Hospital Length of stay (LOS).

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

**Associated surgical service: Vista cervical collar: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back Chapter.

**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: Cervical collar, post-operative (fusion).

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