

<b>Case Number:</b>	CM15-0066879		
<b>Date Assigned:</b>	04/14/2015	<b>Date of Injury:</b>	06/07/2011
<b>Decision Date:</b>	05/15/2015	<b>UR Denial Date:</b>	03/31/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/08/2015

### 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 48-year-old male who sustained an industrial injury on 6/7/11. Injury occurred when he slipped and fell, hitting his face against door. He was diagnosed with closed head trauma, cluster headaches, cervical spine pain with radiculopathy, lumbar disc protrusion with radiculopathy, cervical and lumbar facet syndrome, posttraumatic stress syndrome with anxiety and depression, sexual dysfunction, hypertension, and traumatic brain injury. Records documented monthly psychotropic medication management and psychological evaluations for a diagnosis of major depressive disorder, severe. The 2/6/15 cervical spine MRI impression documented central stenosis of mild to moderate degree at C5/6 and mild degree at C4/5 and C6/7. There was right moderate to severe neuroforaminal stenosis at C5/6 and C6/7, and mild to moderate neuroforaminal stenosis at C4/5. There was left moderate to severe left neuroforaminal stenosis at C6/7, moderate at C5/6, and mild to moderate degree at C4/5. There minimal retrolisthesis at C4 on C5 without facet joint dislocation, and slight retrosubluxation of C5 on C6 without facet joint dislocation. The 2/28/15 cervical spine MRI impression documented C2/3 left facet arthropathy. There were 2 to 2.2 mm disc herniations at C3/4 and C4/5 that abutted the thecal sac, and combined with facet and unciniate arthropathy, there was bilateral neuroforaminal narrowing. There was a 3.6 mm disc herniation at C5/6 that indented the spinal cord producing spinal canal narrowing. There was facet and unciniate arthropathy, bilateral neuroforaminal narrowing, impingement on the C6 exiting nerve roots, and posterior annual tear/fissure. At C6/7, there was 3.2 mm disc herniation that abutted the spinal cord producing spinal canal narrowing, facet and unciniate arthropathy, bilateral neuroforaminal narrowing, impingement on

the C7 exiting nerve roots, and posterior annular tear/fissure. The 3/3/15 neurosurgical report cited constant severe neck pain with activity, and severe back pain radiating down both legs, left worse than right, with numbness and tingling. He continued to be markedly dysfunction. Physical exam documented he was ambulating with a cane with a limp towards the right leg. Cervical range of motion was mildly limited in extension, with 5/5 upper extremity strength, 1+ upper extremity reflexes throughout, and slightly diminished right C8 dermatomal sensation. Cervical spine imaging showed significant discogenic changes at C4/5, C5/6, and C6/7 with bilateral foraminal stenosis. There was canal narrowing and abutment of the spinal cord particularly at C5/6 but no overt spinal cord injury. There were grade 2 Modic changes at the C6/7 disc space. The neurosurgeon opined that his severe headaches and occasional language and speech problems were directly related to his cervical spine disc deterioration that is causing severe neck muscle spasms. He was an excellent candidate for C4 through C7 anterior cervical discectomy and fusion combined with a posterior decompression and fusion at C4 through C7. The 3/31/15 utilization review non-certified the request for C4 through C7 anterior cervical discectomy and fusion combined with a posterior decompression and fusion at C4 through C7/T1. The rationale for non-certification stated that there was no evidence of biomechanical instability to justify anterior and posterior arthrodesis and the injured worker did not suffer from myelopathy but rather radiculopathy.

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

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

#### **C4 Through C7 Anterior Cervical Discectomy And Fusion Combined With A Posterior Decompression And Fusion At C4 Through C7: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

**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; Fusion, posterior 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. 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. Guidelines state that posterior cervical

fusion is under study. A posterior fusion and stabilization procedure is often used to treat cervical instability secondary to traumatic injury, rheumatoid arthritis, ankylosing spondylitis, neoplastic disease, infections, and previous laminectomy, and in cases where there has been insufficient anterior stabilization. Guideline criteria have not been met. This injured worker presents with severe neck pain with activity. Clinical exam findings documented a sensory deficit in the C8 distribution. There was no evidence of focal motor deficit to correlate with imaging evidence of C6 and C7 nerve root compromise. There is no radiographic evidence of segmental spinal instability. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. There are potential psychological issues documented, with no evidence of psychological clearance for spinal surgery. Therefore, this request is not medically necessary.