

<b>Case Number:</b>	CM15-0073881		
<b>Date Assigned:</b>	04/23/2015	<b>Date of Injury:</b>	01/13/2013
<b>Decision Date:</b>	06/11/2015	<b>UR Denial Date:</b>	03/27/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/17/2015

### 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 male who sustained an industrial injury on 1/13/13. Injury occurred while he was pushing a roller tanner, and slipped and fell sideways to the ground. The roller tan then pushed the injured worker and he was pinned between two containers. Past surgical history was positive for lumbar spine surgery on three occasions from 1986-1998. The 1/28/14 bilateral upper extremity electrodiagnostic studies documented no evidence of cervical radiculopathy. The 8/29/14 neurosurgical report cited constant severe grade 8/10 pain over the intrascapular region and neck. He reported numbness and tingling radiated to the arms and hand which he could not localize, and continued to drop stuff. His wife reported that he couldn't hold his head up. Physical exam documented slouched posture, diminished cervical lordosis, and standing and ambulation with a stooped posture. The impression was chronic pain, mood disorder, cerebellar ectopia, C4/5 intervertebral disc herniation with kyphosis, C6/7 intervertebral disc herniation with bi-foraminal stenosis and polyradiculitis, left C2-C7 and right C3-C7 foraminal stenosis, features of bilateral thoracic outlet syndrome, and prior micturition syncope. The neurosurgeon indicated that the injured worker may benefit from decompression of his spinal cord at the C4/5 and C6/7 levels, with reduction of his kyphotic deformity at C4/5. The treatment plan recommended smoking cessation, and right anterior C4/5 and C6/7 discectomies, fusion, and instrumentation. The 2/25/14 cervical spine MRI revealed mild bilateral degenerative facet changes with mild canal stenosis at the C4/5 level with moderate bilateral foraminal stenosis. At the C6/7 level, there were small degenerative facet changes, mild canal stenosis, and moderate bilateral foraminal stenosis greater on the right. The 12/10/14 pain management report

cited constant grade 8-9/10 pain in the back of his head radiating down into the neck and down both arms. He reported it was very painful to move his neck with referred pain into both shoulders, interscapular regions, both hands and long the ulnar distribution. There was functional difficulty noted in activities of daily living. The injured worker took Norco and Some. Range of motion was markedly limited. Spurling's test was negative. There was tenderness to palpation over the cervical paraspinal muscles. Neurologic exam documented normal reflexes, motor function, and sensation. The diagnosis was cervical pain, degenerative disc disease, and radiculopathy. The physician noted the injured worker had not had any prior physical therapy, chiropractic, acupuncture, traction, TENS unit or psychological treatment. A trial of conservative treatment, including 4 visits of physical therapy to provide a home program, was recommended prior to surgical consideration. The 2/12/15 treating physician report cited continued neck pain. The injured worker had been approved for physical therapy but he reported that he developed nausea with mild cervical traction after one session and declined any additional physical therapy. Physical exam documented significantly decreased range of motion and paraspinal tenderness. Neurologic exam was within normal limits. The 3/10/15 treating physician report cited guarding on all range of motion with paraspinal muscle spasms, and evidence of radiculitis with a positive Spurling's. Authorization was requested for right anterior C4/5 and C6/7 discectomies, fusion, and instrumentation. The 3/27/15 utilization review non-certified the request for anterior cervical discectomy and fusion as there was no clear exam or imaging evidence of significant cord compression to support the medical necessity of surgery.

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

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

**Right anterior C4-5 and C6-7 discectomies, fusion, and instrumentation:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 180.

**MAXIMUS guideline:** Decision based on MTUS ACOEM 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. 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. Guideline criteria have not been met. This

injured worker presents with neck pain radiating into the arms with numbness and tingling, and a positive Spurling's test. However, the clinical exam was negative for motor deficit, reflex change, or sensory loss. The electrodiagnostic study was negative for cervical radiculopathy. There is no clear imaging evidence of neural compression at C4/5 or C6/7. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. Additionally, there is no confirmation of smoking cessation documented in the records. Therefore, this request is not medically necessary.