

<b>Case Number:</b>	CM14-0112808		
<b>Date Assigned:</b>	08/01/2014	<b>Date of Injury:</b>	05/04/2014
<b>Decision Date:</b>	09/10/2014	<b>UR Denial Date:</b>	06/19/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/19/2014

### 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 Surgery 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 47 year old male who reported an injury to his neck and low back on May 04, 2014. The clinical note dated 04/26/12 indicates that he presented for follow up regarding lumbar disc arthroplasty. The patient reported that he had been doing well following the procedure; however, he reported neck stiffness. A clinical note dated 03/11/14 indicates the patient having complaints of ongoing myelopathy most significantly in the C6 and C7 levels and the MRI revealed degenerative findings at the C5-6 level along with myelopathy at C6-7. The patient was being recommended for C6-7 arthroplasty. Recommended in a clinical note dated 04/22/14 is for the patient to have a C5-C7 anterior cervical discectomy and fusion (ACDF). He reported numbness and tingling in the upper extremities. A clinical note dated 06/05/14 indicates the injured worker having 5-/5 strength at the left triceps and complaints of ongoing cervical region pain with radiating pain to the upper extremities which was identified as being progressive in nature. Numbness and tingling are also identified in the upper extremities. The injured worker was being recommended for a disc arthroplasty at C5-6 and C6-7. The previous utilization review dated 06/19/14 resulted in a denial as insufficient information had been submitted confirming the medical need for a two level artificial disc replacement.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**C5-C6, C6-C7 cervical arthroplasty:** 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.

**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 Chapter, Disc prosthesis.

**Decision rationale:** The request for C5-6 and C6-7 cervical arthroplasty is not medically necessary. The documentation indicates the injured worker complaining of cervical region pain with radiating pain into the upper extremities. It also indicates the injured worker having minimal strength deficits in the upper extremities. Additionally, there is an indication the patient has complaints of numbness and tingling throughout the left upper extremity and that he has undergone an MRI of the cervical spine; however, no imaging studies were submitted confirming the injured worker's significant pathology. No information was submitted regarding the his completion of any conservative treatment addressing the cervical complaints as well as injections in the cervical region. The Food and Drug Administration (FDA) has recently approved an artificial disc replacement over two levels in the cervical region; however, this is for a very specific device. No information was submitted regarding the request involving the previously approved device over the two levels of the cervical region. Given these factors and taking into account the minimal findings indicating the injured worker's radiculopathy, this request is not fully indicated as medically necessary.

**Pre-op standard labs:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Preoperative lab testing.

**Decision rationale:** Since the primary procedure is not medically necessary, non of the associated services are medically necessary.

**Chest X-Ray:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Preoperative testing, general.

**Decision rationale:** Since the primary procedure is not medically necessary, non of the associated services are medically necessary.

**EKG:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Preoperative electrocardiogram (ECG).

**Decision rationale:** Since the primary procedure is not medically necessary, non of the associated services are medically necessary.

**One (1) night in-patient stay:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**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 Chapter, Hospital length of stay (LOS).

**Decision rationale:** Since the primary procedure is not medically necessary, non of the associated services are medically necessary.