

<b>Case Number:</b>	CM14-0166453		
<b>Date Assigned:</b>	10/23/2014	<b>Date of Injury:</b>	08/15/2002
<b>Decision Date:</b>	11/26/2014	<b>UR Denial Date:</b>	09/29/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/09/2014

### 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 Spine Surgeon 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 58-year-old male who reported an injury on 10/03/2000. The mechanism of injury involved repetitive activity. The current diagnoses include status post C5-7 fusion, status post hardware removal, status post adjacent level fusion at C7-T1, status post anterior lumbar interbody fusion at L5-S1 with pseudarthrosis, radiculopathy in the bilateral lower extremities, right upper extremity rule out right shoulder pathology, right shoulder internal derangement, status post laminotomy and foraminotomy with Coflex procedure at L3-5 on 11/06/2013, and transfer lesion at C3-5 with foraminal stenosis and right upper extremity radiculopathy. Previous conservative treatment is noted to include physical therapy, trigger point injections, acupuncture, chiropractic therapy, massage therapy, and psychotherapy. The injured worker was evaluated on 08/11/2014 with complaints of ongoing cervical spine pain with radiation into the right interscapular region at the C5 distribution. Physical examination revealed focal tenderness in the bilateral upper trapezii, weakness in the deltoid and biceps on the right side, diminished strength in the left upper extremity, decreased sensation in the right upper extremity along the lateral arm and forearm, 40 degrees forward flexion, 45 degrees extension, 30 degrees right and left lateral bending, and 60 degrees right and left rotation. Treatment recommendations at that time included an anterior cervical discectomy and decompression of the neural elements and neural foramina with placement of an artificial disc at C3-5. A Request for Authorization form was then submitted on 09/04/2014. It is noted that the injured worker underwent an MRI of the cervical spine on 06/05/2014 which indicated disc protrusion at C3-4 with partial effacement of the anterior cerebrospinal fluid space, moderate right and mild left neural foraminal stenosis; disc protrusion at C4-5 with complete effacement of the anterior cerebrospinal fluid space and flattening of the anterior contour of the cord, moderate right and mild left neural foraminal stenosis, and a slight increase of the degree of disc protrusion when

compared to a previous study. The injured worker also underwent a CT scan of the cervical spine on 08/05/2014, which indicated mild right sided uncovertebral joint hypertrophy and mild right sided neural foraminal stenosis at C3-4 and a 1-2 mm diffuse disc osteophyte complex with right sided facet arthropathy resulting in moderate to severe right sided neural foraminal stenosis at C4-5.

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

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

**Anterior Cervical Discectomy and decompression of neural elements and neural foramina with placement of artificial discs C3-C4, C4-C5: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 179-180. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck & Upper Back Chapter, Discectomy/Laminectomy/Laminoplasty, Disc Prosthesis

**Decision rationale:** California MTUS/ACOEM Practice Guidelines state a referral for surgical consultation is indicated for patients who have persistent, severe, and disabling shoulder or arm symptoms, activity limitation for more than 1 month, clear clinical, imaging, and electrophysiologic evidence of a lesion, and unresolved radicular symptoms after receiving conservative treatment. The Official Disability Guidelines state disc prosthesis is currently under study. A discectomy/laminectomy is indicated where there is evidence of radicular pain and sensory symptoms in a cervical distribution that correlates with the involved cervical level, evidence of motor weakness or reflex changes or positive EMG findings, abnormal imaging studies, and a failure of at least 6 to 8 weeks of conservative treatment. While it is noted that the injured worker demonstrates tenderness, hyperesthesia in the right upper extremity, diminished range of motion of the cervical spine, and has exhausted conservative treatment, there is a lack of long term literature revealing efficacy for the requested artificial disc replacement. The Official Disability Guidelines state disc prosthesis is currently under study. Therefore, the current request is not medically appropriate at this time.

**Associated surgery service: Inpatient Stay, 2 days: Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

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

**Associated surgery service: Pre-Op Clearance: Consultation: Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

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

**Associated surgery service; Pre-Op Labs: CBC, CMP, PT, PTT, Urine Drug Screen:**  
Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

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

**Associated surgery service: Pre-Op: EKG:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

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

**Associated surgery service: Pre-Op: Chest X-ray and additional testing as necessary:**  
Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

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

**Associated surgery service: Post-Op DME Purchase: Soft Cervical Collar:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

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

**Associated surgery service: Post-Op Fusion DME Purchase: Miami J Collar:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

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

**Associated surgery service: Post-Op DME: Cold Therapy unit- no duration:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

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

**Associated surgery service: Transportation: Commutes greater than 15 miles from home:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

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

**Associated surgery service: Assistant Surgeon:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

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