

Case Number:	CM14-0062860		
Date Assigned:	08/13/2014	Date of Injury:	10/28/2011
Decision Date:	09/23/2014	UR Denial Date:	04/11/2014
Priority:	Standard	Application Received:	05/05/2014

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 California. 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 claimant is a 52-year-old female who sustained injuries to her neck while performing repetitive computer activities at work on October 28, 2011. The medical records provided for review include documentation that an MRI report dated March 14, 2014 identified a small C3-4 disc osteophyte complex with mild to moderate foraminal narrowing, at C4-5, C5-6 and C6-7 levels there was disc bulging and protrusion resulting in mild to moderate underlying bilateral foraminal narrowing. The progress report dated March 28, 2014 described continued complaints of neck pain and radiating upper extremity pain with physical examination showing 4+/5 strength with wrist extension and long finger extension on the right and biceps and triceps testing on the left and numbness in a C8 dermatomal distribution. It was documented that prior electrodiagnostic studies performed on April 15, 2013 showed left C8 radiculopathy and median nerve compression at the carpal tunnel. The recommendation was made for multilevel fusion surgery at the C4-5, C7-T1 and T1-T2 levels and an artificial disc replacement to be performed at C5-6.

IMR ISSUES, DECISIONS AND RATIONALES

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

Anterior spinal decompressive surgeries at C4-5, C5-6, C7-T1 and T1-2 with reconstructions including anterior discectomy and fusion at C4-5, C7-T1 and T1-2 with an artificial disk replacement at C5-6: 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): 180-181. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Worker's Comp, 18th Edition, 2013 Updates: neck procedure - Disc prosthesis Under study, with recent promising results in the cervical spine, but not recommended in the lumbar spine. 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. These should include an evaluation of the subset of patient who will most benefit from this procedure as well as study of advantages/disadvantages of disc design and surgical procedure in terms of outcomes (particularly for development of heterotopic ossification and adjacent segment disease). This recommendation is based on balancing what we know so far about the benefits and the risks for the patient. Adjacent segment disease seems to be a natural aging process, and ADR has not proven any benefit in altering that progression. The risks of heterotopic calcification associated with ADR may make it a sure way to end up with a solid fusion, and major risks also include potential revisions and technical learning curve issues with widespread use. Overall Comparison to Fusion: Overall studies have demonstrated statistically significant non-inferiority of ADR vs. fusion with superior trending on many outcomes but limited evidence of statistical superiority. This has persisted for longer-term follow-up (three to five years). Long-term studies have shown that necessity of adjacent-level surgery is similar in both the fusion and ADR groups along with similar rates of development of adjacent-segment disease. Complication rates are similar. Study quality is often severely limited with high dropout rates and there is no comparison to a non-surgical treatment. Neither treatment has been found to produce complete disappearance of symptoms. Return to work appears earlier in the ADR group but overall employment rate is not different at 2 years (including for a workers' compensation cohort) and 5 years. (Zechmeister, 2011) (Steinmetz, 2008) (Jawahar, 2010) (Kim, 2009) (Garrido, 2010) (Fekete, 2010) (Dettori, 2008) (Pointillart, 2001) (Cinotti, 1996) (Klara, 2002) (Zeegers, 1999) (Sekhon, 2003) (Sekhon, 2004) (Porchet, 2004) (Pimenta, 2004) (Sasso, 2007) (Heller, 2009) (Mummaneni, 2007) (Murrey, 2009) (Burkus, 2010) (ECRIb, 2009) (Tumialán, 2010) (Delamarter, 2010) (Kelly, 2011) See also the complete list, discussion, and rating of other Disc prosthesis references in the Fusion References Chapter. Recommended Indications: 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 si

Decision rationale: Based on the California ACOEM Guidelines and supported by Official Disability Guidelines, the proposed anterior spinal decompressive surgeries at C4-5, C5-6, C7-T1 and T1-2 with reconstruction including anterior discectomy and fusion at C4-5, C7-T1 and T1-2 with an artificial disk replacement at C5-6 cannot be recommended as medically necessary. First and foremost, artificial disc replacement is not recommended in the neck per ODG Guidelines because its efficacy remains under study. Also, artificial disc replacement is particularly not recommended for multilevel disease. In regards to the claimant's surgical process as a whole, there is very little to clinically correlate the requested levels of surgery C4-5 through

T1-2 directly to the claimant's current physical examination findings or compressive findings on imaging. Electrodiagnostic studies only showed evidence of a C8 radiculopathy. The requested five level surgical processes given the claimant's current clinical picture would not be supported.