

Case Number:	CM15-0183877		
Date Assigned:	09/24/2015	Date of Injury:	02/06/2015
Decision Date:	10/29/2015	UR Denial Date:	08/18/2015
Priority:	Standard	Application Received:	09/18/2015

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 52-year-old male who sustained an industrial injury on 2/06/15. Injury occurred when he was climbing onto a man-lift and hit his head on a cross bar, jamming his neck. Conservative treatment included medications, physical therapy, and activity modification. The 7/7/15 cervical spine MRI impression documented spondylitic changes at C5/6 and C6/7, resulting in mild bilateral C5/6 and moderate bilateral C6/7 neuroforaminal stenosis. There was mild C3/4 left neuroforaminal narrowing relative to degenerative changes in the uncovertebral joint. There was a 1 mm broad-based annular bulge at C5/6 with mild bilateral neuroforaminal narrowing related to degenerative changes in the uncovertebral joints. The 7/7/15 cervical spine x-ray impression documented C6/7 spondylosis with no instability on flexion-extension. The 7/23/15 treating physician report cited severe neck and right arm radicular pain with right arm weakness. Pain is worse when extending the neck. Physical exam documented normal physiologic cervical lordosis, normal cervical palpation, and drastically abnormal cervical range of motion. There was 4/5 right triceps and wrist flexor weakness. Upper and lower extremity deep tendon reflexes were symmetrical and 2+, with plantar reflexes down-going. There was reduced sensation over the right hand first web space. Imaging showed severe stenosis at C6/7 with Modic changes, 70% loss of disc height and bilateral foraminal and central stenosis. There was radiographic evidence of collapse at C6/7 with bone spurs anteriorly and posteriorly into the spinal canal. The injured worker had progressive worsening neck pain and radiating right arm pain with triceps weakness and atrophy. There was imaging evidence of severe central canal and bilateral neuroforaminal stenosis at C6/7 with C5/6 left sided foraminal narrowing, and 70-80% collapse of C6/7 on radiographs. He had failed physical therapy and interventional pain injections. Complete decompression of the C6/7 segmental was needed from the anterior

approach. Due to the nature of his job as a processing plant inspector, repetitive neck bending to look up and around objects was needed. The ideal solution would be a total disc replacement at C6/7 which was FDA approved and studies supported it as effective if not superior to single level fusion. Authorization was requested for anterior discectomy and total disc replacement at C6/7, possible arthrodesis C6/7. The 8/18/15 utilization review non-certified the retrospective request for anterior discectomy and total disc replacement at C6/7, possible arthrodesis C6/7 based on the ACOEM and Official Disability Guidelines. The 9/24/15 treating physician report appealed the denial of total disc replacement. The injured worker had severe headaches, right arm pain and weakness. Physical exam was unchanged from 7/23/15. The treatment plan recommended total disc replacement at C6/7, if not approved, then will request anterior cervical discectomy and fusion at C6/7. The total disc replacement was requested based on the nature of his job, which involved turning and bending his neck in his work as an inspector.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective Anterior discectomy and total disc replacement at C6-7, possible arthrodesis at C6-7: Overturned

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004.

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, Disc prosthesis.

Decision rationale: The California MTUS are silent regarding artificial disc replacement. The Official Disability Guidelines indicate that disc prostheses are under study, with recent promising results in the cervical 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. 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 six weeks of non-operative treatment and present with arm pain and functional/ neurological deficit. At least one of the following conditions should be confirmed by imaging (CT, MRI, X-ray): (1) herniated nucleus pulposus; (2) spondylosis (defined by the presence of osteophytes); & (3) loss of disc height. General indications have been met for single level cervical artificial disc replacement. This patient presents with persistent severe and function-limiting neck pain radiating into the right arm with clinical evidence of motor and sensory deficits. Clinical exam findings are consistent with imaging evidence of severe central and foraminal stenosis at C6/7. There is radiographic evidence of collapse at C6/7 with bone spurs anteriorly and posteriorly into the spinal canal. There is minimal adjacent segment disease. Detailed evidence of at least 6 weeks of recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. The treating physician has opined the medical necessity of restoring cervical range of motion with a total disc replacement to allow for return to the injured worker's normal occupation. Therefore, this request is medically necessary.