

<b>Case Number:</b>	CM15-0211758		
<b>Date Assigned:</b>	10/30/2015	<b>Date of Injury:</b>	03/10/2013
<b>Decision Date:</b>	12/22/2015	<b>UR Denial Date:</b>	10/22/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/27/2015

### 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: Minnesota, Florida  
 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:

The injured worker is a 50 year old female who sustained an industrial injury on 3-10-13. A review of the medical records indicates that the worker is undergoing treatment for neck pain and right shoulder pain. Subjective complaints (10-7-15) include right sided neck pain and right arm pain starting in 2010, the arm pain improved with shoulder surgery for a SLAP tear. She reports pain is preventing her from working. Objective findings (10-7-15) include decreased rotation of the neck to the right-(half of the rotation compared to turning to the left), and a normal sensory exam right and left. MRI of the cervical spine is noted to reveal "C5-C6 degenerative disc disease with central herniation and bilateral foraminal stenosis, C6-C7 central disc herniation without significant foraminal or central stenosis, no significant central stenosis, facet joints without degenerative changes or fluid." Electromyography (7-20-15) is noted to reveal "possible mild C6 neuropathy." Current medications are Ibuprofen, Flexeril, and Pennsaid Solution. Previous treatment includes physical therapy, chiropractic treatment, and C6-7 epidural steroid injection (reported as helped "a little bit"). The requested treatment of total disc arthroplasties cervical at C5-C7 was non-certified on 10-22-15.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Total disc arthroplasty cervical at C5-C7: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck & Upper Back Chapter (Online Version) Disc prosthesis.

**MAXIMUS guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation ODG: Section: Neck and upper back. Topic: Disc prosthesis.

**Decision rationale:** The injured worker is a 49-year-old female with a date of injury of 3/10/2013. She underwent a right shoulder arthroscopy with SLAP repair in 2013 with some improvement. The current complaint is axial neck pain without radicular pain. She underwent physical therapy, chiropractic treatment, and epidural steroid injection at C6-7 which helped a little bit. The MRI scan of the cervical spine is dated May 21, 2015. According to the report there was an annular bulge at C5-6 and degenerative spurring resulting in moderate left and mild to moderate right foraminal stenosis and mild to moderate central canal stenosis. At C6-7 there was mild left foraminal and central canal stenosis. Probable atypical hemangiomas were noted at C6 and C7. Progress notes from October 8, 2015 document numbness/tingling of the 3, 4, 5 digits of both hands with noted cervical pain with extension. EMG completed on 7/28/2015 noted possible mild C6 neuropathy based on H- reflex and sparse fibrillation potentials. On examination her BMI was 27.27. Examination of the cervical spine revealed tenderness, hypertonicity and spasm on both sides. Examination of the right shoulder revealed positive Hawkins, Neer, and belly press test. Liftoff test was positive. Speeds test was positive. Apprehension test, anterior stress test, posterior stress test and Jobe relocation tests were negative. There was no instability. Motor examination revealed 5/5 grip on both sides, finger extensors 4/5 on the right and 5/5 on the left, wrist flexors 5/5 on both sides and wrist extensors 5/5 on both sides and elbow flexors 5/5 on both sides. Sensory examination was normal. Reflexes were normal. A request for 2 level artificial disc replacement was noncertified by utilization review. California MTUS guidelines indicate surgical considerations for severe spinovertebral pathology and severe debilitating symptoms with physiologic evidence of specific nerve root or spinal cord dysfunction corroborated on appropriate imaging studies that did not respond to conservative therapy. The guidelines indicate surgical consultations for patients who have persistent severe and disabling shoulder or arm symptoms, activity limitation for more than one month or with extreme progression of symptoms, clear clinical, imaging, and electrophysiologic evidence, consistently indicating the same lesion that has been shown to benefit from surgical repair in both the short and long-term and unresolved radicular symptoms after receiving conservative treatment. In this case, the symptoms are primarily in the neck and in the right shoulder area and documentation does not indicate significant pain in the right arm. There is no sensory deficit. Objective motor deficit is not documented. Deep tendon reflexes are normal. The EMG shows possible C6 radiculopathy of mild degree which does not support a two-level artificial disc replacement at C5-6 and C6-7. Although ODG guidelines recommend artificial disc replacement for single level cervical degenerative disc disease, two-level artificial disc replacement has been approved by FDA. ODG guidelines also necessitate presence of arm pain and functional/neurological deficit. Decompression of nerve roots and/or the spinal canal is often the primary intervention that necessitates disc replacement with a goal of restoration of intervertebral disc and foraminal height to prevent recurrence of nerve root compression. Recommended exclusions include evidence of facet arthritis, spinal instability or significant

deformity which is not present in this case. Others suggested exclusions include axial neck pain as the solitary present presenting symptom. Osteoporosis and spinal stenosis by hypertrophic spondylo-arthritis, severe spondylosis with bridging osteophytes, loss of disc height greater than 50% or absence of motion less than 2%, active infection, material allergies, presence of underlying comorbid diseases such as HIV or rheumatoid arthritis are relative contraindications. In this case, the neurologic examination is relatively benign with no objective neurologic findings. The EMG also does not support 2 level disease. Although the above contraindications are not present, the primary complaint is neck pain. In the absence of objective neurologic deficit California MTUS guidelines do not support surgery. As such, the medical necessity of the requested two-level artificial disc replacement at C5-6 and C6-7 is not medically necessary.