MAXIMUS Federal Services

Case Number:	CM15-0031948		
Date Assigned:	02/25/2015	Date of Injury:	03/19/2014
Decision Date:	04/10/2015	UR Denial Date:	02/05/2015
Priority:	Standard	Application Received:	02/20/2015

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: Texas, California
Certification(s)/Specialty: Family Practice

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 40-year-old male, who sustained an industrial injury on 03/19/2014. The injured worker is a police officer that reported experiencing pain to the right neck and shoulder secondary a person resisting arrest from the injured worker. Diagnoses include symptomatic disc herniation at cervical five to six. Treatment to date has included physical therapy, magnetic resonance imaging of the cervical spine, and medication regimen. In a progress note dated 01/26/2015 the treating provider reports neck pain that radiates to the posterior shoulder to the right arm and to the first two fingers with a pain rating of a six out of ten. Physical examination of the cervical spine revealed 4/5 strength and absent brachioradialis reflex on right side, positive Spurling sign, numbness in thumb and index finger. The treating physician requested placement of a prosthetic disc at cervical five to six noting that the injured worker has had a course of physical therapy and has been on modified work, along with the injured worker not having interest in injection therapy. The patient has had MRI of the cervical spine on 8/22/14 that revealed disc protrusion and foraminal narrowing at C4-5 and C5-6 level. The medication list includes Ibuprofen.

IMR ISSUES, DECISIONS AND RATIONALES

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

Inpatient artificial disc replacement at the C5-C6 level: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation FDA. GOV: Cervical Dis Arthroplasty: Michael Zindrick, Mitchel B. Harris, Steven Craig Humhreys, Patrick T. O'Leary, Gary Schnelderman, William C. Watters III, Charles M. Turkelson, Janet L. Wies, and laura Raymond J Arn Acad Orthop Surg October 2010; 18:631-637.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 180. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck & Upper Back (updated 11/18/14)ADR (artificial disc replacement)Disc prosthesis.

Decision rationale: Request: Inpatient artificial disc replacement at the C5-C6 level Per the cited guidelines "Referral for surgical consultation is indicated 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. Unresolved radicular symptoms after receiving conservative treatment." Per the cited ODG guidelines, regarding artificial disc replacement or 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." Per the cited guidelines this procedure is considered as under study. A detailed response to a recent course of conservative therapy, including PT, for the cervical spine is not specified in the records provided. Previous conservative therapy notes are not specified in the records provided. The patient has had MRI of the cervical spine on 8/22/14 that revealed disc protrusion and foraminal narrowing at C4-5 and C5-6 level. Electrophysiologic evidence of neurological abnormalities in upper extremities is not specified in the records provided. Physical examination of the cervical spine revealed 4/5 strength and absent brachioradialis reflex on right side, positive Spurling sign, numbness in thumb and index finger. The duration of these symptoms, and any progression if any, was not specified in the records provided. The medical necessity of the request for Inpatient artificial disc replacement at the C5-C6 level is not fully established in this patient.

associated surgical service: hospital length of stay (LOS) one (1)day: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck & Upper Back (updated 11/18/14)Hospital length of stay (LOS).

Decision rationale: Request: associated surgical service: hospital length of stay (LOS) one (1) day As per cited guideline ODG hospital length of stay (LOS) guidelines: Artificial Disc (84.62: Insertion of total spinal disc prosthesis, cervical) Actual data: median 1 days; mean 1.4 days (0.1); discharges [redacted]; charges (mean) [redacted]. Best practice target (no complications) '1 day. 'The medical necessity of the request for Inpatient artificial disc replacement at the C5-C6 level is not fully established in this patient. Therefore the medical necessity of the associated surgical service: hospital length of stay (LOS) one (1) day is not fully established in this patient.

Outpatient per-operative clearance: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Page(s): 127. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chapter: Low Back (updated 03/03/15) Preoperative testing, general.

Decision rationale: Request: Outpatient pre-operative clearance MTUS guidelines American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 7, Independent Medical Examinations and Consultations, page 127 Per the cited guidelines, "The occupational health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise."In addition, per the cited guidelines "Preoperative testing (e.g., chest radiography, electrocardiography, laboratory testing, urinalysis) is often performed before surgical procedures. These investigations can be helpful to stratify risk, direct anesthetic choices, and guide postoperative management, but often are obtained because of protocol rather than medical necessity. The decision to order preoperative tests should be guided by the patient's clinical history, comorbidities, and physical examination findings. Patients with signs or symptoms of active cardiovascular disease should be evaluated with appropriate testing, regardless of their preoperative status. Routine preoperative tests are defined as those done in the absence of any specific clinical indication or purpose and typically include a panel of blood tests, urine tests, chest radiography, and an electrocardiogram (ECG). These tests are performed to find latent abnormalities, such as anemia or silent heart disease, that could impact how, when, or whether the planned surgical procedure and concomitant anesthesia are performed. It is unclear whether the benefits accrued from responses to true-positive tests outweigh the harms of false-positive preoperative tests and, if there is a net benefit, how this benefit compares to the resource utilization required for testing. An alternative to routine preoperative testing for the purpose of determining fitness for anesthesia and identifying patients at high risk of postoperative complications may be to conduct a history and physical examination, with selective testing based on the clinician's findings. However, the relative effect on patient and surgical outcomes, as well as resource utilization, of these two approaches is unknown. (AHRQ, 2013) The latest AHRQ comparative effectiveness research on the benefits and harms of routine preoperative testing, concludes that, except for cataract surgery, there is insufficient evidence comparing routine and per-protocol testing. (AHRQ, 2014)." The medical necessity of the

request for Inpatient artificial disc replacement at the C5-C6 level is not fully established in this patient. Therefore, the medical necessity of Outpatient pre-operative clearance is not fully established for this patient.