

<b>Case Number:</b>	CM15-0046207		
<b>Date Assigned:</b>	03/18/2015	<b>Date of Injury:</b>	11/26/2014
<b>Decision Date:</b>	05/08/2015	<b>UR Denial Date:</b>	03/03/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/11/2015

### 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  
 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 male who reported an injury on 11/26/2014. There was a Request for Authorization submitted for review dated 02/24/2015. The documentation of 02/24/2015 revealed an initial evaluation. The documentation indicated the mechanism of injury was the injured worker was putting a roll of paper into a label machine and twisted to the left and felt a pop in his back. The injured worker indicated that his hand did not work right. The arm experienced numbness and tingling all the time. The injured worker had difficulty gripping. Additionally, the documentation indicated the injured worker utilized a Medrol Dosepak and had not performed physical therapy. The injured worker indicated that in 2009 he had something similar; however, it did not affect his arm, just his back, and he performed therapy (which did not help). The documentation indicated the injured worker underwent an x-ray of the cervical spine on 02/24/2015, which revealed moderate bony foraminal stenosis on the right at C6-7. The injured worker was noted to have undergone an MRI of the cervical spine without contrast on 01/29/2015, which the physician documented, indicated the injured worker had multilevel degenerative disc disease, most significant at C5-6 and C6-7. There was moderate spinal canal stenosis at C6-7. There was severe right C6-7 neural foraminal stenosis with a prominent right foraminal disc protrusion. The physical examination revealed the injured worker had right triceps, extensor digitorum, and wrist flexion strength of +3/5. The sensory examination revealed hypoesthesia in a C7 distribution on the right. The diagnoses included displacement of cervical intervertebral disc, cervical pain, and cervical radiculopathy. The physician documentation indicated prior treatments included heat, ice, prescription medication, and physical therapy, for

which the injured worker's response was unchanged. The treatment plan and discussion included the injured worker should stop smoking. The request was made for an anterior cervical discectomy with foraminal decompression and disc replacement. The official MRI revealed at the level of C6-7, there was moderate disc bulging, more eccentric to the right with moderate spinal canal stenosis. There was severe right and moderate to severe left neural foraminal stenosis. It further indicated the injured worker had moderate spinal canal stenosis at C6-7 and severe right C6-7 neural foraminal stenosis with a prominent right foraminal disc protrusion.

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

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

#### **Anterior discectomy and disc replacement C6-7: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck & Upper Back Chapter, ADR, disc replacement.

**Decision rationale:** The American College of Occupational and Environmental Medicine indicates that a surgical consultation may be appropriate for injured workers who have activity limitation for more than 1 month or with extreme progression of symptoms. There should be documentation of clear clinical, imaging, and electrophysiological evidence consistently indicating the same lesion that has been shown to benefit from surgical repair in both the short and long term. There should be documentation of unresolved radicular symptoms after receiving conservative treatment. They do not address Artificial Disc Replacement. As such, secondary guidelines were sought. The Official Disability Guidelines indicate that Cervical Disc replacement is under study, with recent promising results in the cervical spine, but not recommended in the lumbar spine. The general indications for currently approved cervical-ADR devices (based on protocols of randomized-controlled trials) are for injured workers 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. (Dettori, 2008) At the current time radiculopathy is an exclusion criteria for the FDA studies on lumbar disc replacement, whereas cervical radiculopathy is an inclusion criteria for the FDA investigations of cervical arthroplasties. The clinical documentation submitted for review failed to provide the duration of conservative care, including recent physical therapy. Additionally, there was a lack of documentation indicating the injured worker had a herniated nucleus pulposus, spondylosis, or a loss of disc height. The physical therapy was noted to be in 2009. There was no notation of recent physical therapy. The injured worker had objective findings upon physical examination. Given the above, the request for anterior discectomy and disc replacement C6-7 is not medically necessary.

**Associated Surgical Services: One day hospital stay: 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 Surgical Services: Pre-operative evaluation:** 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 Surgical Services: Pre-operative lab: CBC, Chem, U/A, PT/PTT, EKC, CXR:**  
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 Surgical Services: Post Operative Physical Therapy 2 Times a Week for 6 Weeks for Neck:** 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.