

<b>Case Number:</b>	CM14-0210838		
<b>Date Assigned:</b>	02/03/2015	<b>Date of Injury:</b>	06/14/2008
<b>Decision Date:</b>	03/06/2015	<b>UR Denial Date:</b>	12/05/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/16/2014

### 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. 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:

This injured worker is a 54-year-old male with a date of injury 06/14/2008. The mechanism of injury is not provided. His diagnoses include displacement of cervical disc with myelopathy, intervertebral disc disorder with myelopathy. Past treatments included therapy and epidural steroid injections. His diagnostic studies included an MRI of the cervical spine performed on 11/18/2014, which revealed C5-6 artificial disc obscures to soft tissue detail of the mid cervical spine. The C2-3, C3-4, and C7-T1 disc space are unchanged. The past surgical history included an anterior cervical discectomy and decompression and cervical disc replacement at C5-6 in 08/2011, he had a radiofrequency ablation on 04/11/2013. The injured worker presented on 11/21/2014 for re-evaluation of his cervical spine MRI. He complains of pain in the left upper extremities and continues to have low neck pain radiating to the arm. Physical examination revealed moderate stiffness in his neck with mild decreased range of motion in all planes. He has diathesis into the left and right upper extremities, specifically to the index and long fingers. There is moderate lower cervical muscle spasm noted. His current medications are Norco, Robaxin, Neurontin, and Celebrex. The treatment plan is a disc replacement at C6-7. The request is for a spinal C6-7 total disc arthroplasty with surgical assistant and intraoperative neurophysiological monitoring at [REDACTED] with a 1 day stay. The rationale is he has had only temporary results from his C6-7 epidural injections and the MRI shows a protruded disc at C6-7. The Request for Authorization dated 11/21/2014 is provided.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**spinal C6-7 total disc arthroplasty with surgical assistant and intraoperative neurophysiological monitoring at [REDACTED] with a one day stay:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

**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, Disc prosthesis.

**Decision rationale:** The request for spinal C6-7 total disc arthroplasty with surgical assistant and intraoperative neurophysiological monitoring at [REDACTED] with a one day stay is not medically necessary. The injured worker presented on 11/21/2014 with continued complaints of pain in the neck with radiation down the left arm. He has a 6 year history of neck pain. California MTUS/ACOEM Guidelines do not address. The Official Disability Guidelines state that disc prosthesis is under study with the most recent promising results on the cervical spine. The recommended indications are for currently approved cervical ADR devices based on protocols of randomized control trials or for the patients with intractable, symptomatic single level cervical DDD who have failed at least 6 weeks of nonoperative treatment and present with arm and functional/neurological deficit. At least one of the following conditions should be confirmed by imaging (1) herniated nucleus pulposus, (2) spondylosis defined by the presence of osteophytes, and (3) loss of disc height. 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. 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. The documentation from the recent MRI does not corroborate a disc protrusion at C6-7. There is no documentation that the injured worker had failed recent conservative treatments such as muscle relaxants, therapy, a TENS unit, or other conservative therapy. According to the guidelines, arthroplasty with an artificial displacement is contraindicated in patients who have had multiple areas of degeneration. Since the spinal disc arthroplasty is not recommended, the surgical assistant would not be indicated, and the intraoperative neurophysiology monitoring at [REDACTED] with a 1 day stay would not be indicated. As such, the request is not medically necessary.

**pre-op medical clearance, including labs: CBC, CMP, PT/PTT, UA, and possible chest x-ray with [REDACTED]** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Preoperative testing, general.

**Decision rationale:** The request for pre-op medical clearance, including labs: CBC, CMP, PT/PTT, UA, and possible chest x-ray with [REDACTED] is not medically necessary. The California MTUS Guidelines do not address. According to the Official Disability Guidelines, preoperative testing, general are often performed before surgical procedures and can be helpful to stratify risk, direct anesthetic choices, and guide postoperative management, but are often 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. Since the requested operation was denied, and therefore there is no medical necessity for these studies and the request is not medically necessary.

**post-op cervical collar (#L0174) - dispensed at doctor's office: Upheld**

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

**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, Collars (cervical).

**Decision rationale:** The request for post-op cervical collar (#L0174) - dispensed at doctor's office is not medically necessary. The California MTUS Guidelines do not address. The Official Disability Guidelines do not recommend the use of cervical collars for neck sprains. However, cervical collars are frequently used after surgical procedures in the emergent setting following suspected trauma to the neck where it is essential that an appropriately sized brace be selected that properly fits. However, since the requested spinal surgery was denied, therefore, there is no medical necessity for the postoperative surgical collar and the request is not medically necessary.

**post-op Vascutherm cold therapy unit, cervical spine - 14 day rental: Upheld**

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

**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, Cold packs.

**Decision rationale:** The request for post-op Vascutherm cold therapy unit, cervical spine - 14 day rental not medically necessary. The California MTUS Guidelines do not address cold compression units. The Official Disability Guidelines state cold packs are recommended; however, there is insufficient testing to determine the effectiveness of any of the heat/cold applications in treating mechanical neck disorders. However, since the requested spinal surgery was denied, and therefore, there is no medical necessity for the postoperative cold therapy unit, this request is not medically necessary.

**home health care (cervical spine) - initial visit, plus 1-2 more visits, for skilled observation of incision healing, pain management, neurologic status, home safety and equipment needs:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Home health services Page(s): 51.

**Decision rationale:** The request for home health care (cervical spine) - initial visit, plus 1-2 more visits, for skilled observation of incision healing, pain management, neurologic status, home safety and equipment needs is not medically necessary. According to the California MTUS Guidelines, home health services are recommended only for those injured workers who are homebound on a part time or intermittent basis generally up to more than 35 hours per week. However, since the requested surgical spine operation was not approved, and therefore, there is no medical necessity for the home health services. As such, the request is not medically necessary.

**post-op physical therapy - cervical spine, twice weekly for 6 weeks:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 26.

**Decision rationale:** The California MTUS Guidelines recommend a general course of therapy postsurgical treatment and an initial course of therapy means 1 half the number of visits specified in the general course of therapy. However, since the spinal surgery operation was denied, therefore, there is no medical necessity for the postop physical therapy, cervical spine, twice a week for 6 weeks. As such, the request is not medically necessary.