

Case Number:	CM15-0111722		
Date Assigned:	06/18/2015	Date of Injury:	06/07/2013
Decision Date:	07/22/2015	UR Denial Date:	05/14/2015
Priority:	Standard	Application Received:	06/09/2015

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: New York

Certification(s)/Specialty: Neurological 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 45-year-old female, who sustained an industrial injury on 6/7/13. She has reported initial complaints of right neck and right shoulder injury. The diagnoses have included displaced cervical intervertebral disc, brachial neuritis/radiculitis, cervical degenerative disc disease (DDD), right cervical disc protrusion with a central foraminal stenosis and cervical radiculopathy. Treatment to date has included medications, activity modifications, off work, diagnostics, cervical epidural steroid injection (ESI), physical therapy, trigger point injections, nerve block, neurology consult and acupuncture. Currently, as per the physician progress note dated 4/26/15, the injured worker complains of neck, right shoulder and right upper extremity pain. She notes a sense of heaviness in the right arm and pain. The symptoms are constant. She also notes numbness at times in the fingers and right arm. It is noted that compared to one year ago she is feeling worse. She also notes difficulty with staying asleep due to pain. The cervical spine exam reveals tenderness to palpation in the right side of the neck and in the trapezial area. She is able to flex 20 degrees, extend 20 degrees, laterally rotate 45 degrees in either direction and laterally rotate 15 degrees in either direction. The sensation is diminished on the right side from C3-T1 in all distributions. The current medications included Baclofen, Diclofenac, and Gralise. The diagnostic testing that was performed included Magnetic Resonance Imaging (MRI) of the cervical spine dated 3/26/15 reveals cervical degenerative changes, satisfactory alignment, and spinal stenosis with cord effacement. The physician noted that she had a good trial of non - operative management and at this point she would like to proceed with surgery. The physician requested treatments included C5-6 discectomy total disc arthroplasty, associated surgical services: Assistant surgeon / PA, Associated surgical services: Pre-op testing: CBC, BMP, PT, PTT, UA, Chest x-ray, Electrocardiogram (EKG), Associated surgical services: Post-op AP lateral cervical x-ray and Norco 7. 5mg #150 (post-operative).

IMR ISSUES, DECISIONS AND RATIONALES

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

C5-6 discectomy, total disc arthroplasty: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 183. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck & Upper Back.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178-180. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck Chapter-disc prosthesis.

Decision rationale: The California MTUS guidelines recommend cervical surgery when the patient has had severe persistent, debilitating, upper extremity complaints referable to a specific nerve root or spinal cord level corroborated by clear imaging, clinical examination and electrophysiological studies. Documentation does not show pathology limited to the C5-6 interspace. The guidelines note the patient would have failed a trial of conservative therapy. The guidelines note the surgical repair proposed for the lesion must have evidence of efficacy both in the short and long term. The ODG guidelines note the cervical disc replacement is under study and is not yet recommended. The requested treatment: C5-6 discectomy, total disc arthroplasty is NOT Medically necessary and appropriate.

Associated surgical services: Assistant surgeon / PA: 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.

Pre-op testing: CBC, BMP: 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.

Post-op AP lateral cervical x-ray: 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.

Norco 7. 5mg #150 (post operative): 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 service: PT/PTT: 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 service: UA: 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 service: Chest x-ray: 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 service: EKG: 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.