

<b>Case Number:</b>	CM15-0114093		
<b>Date Assigned:</b>	06/22/2015	<b>Date of Injury:</b>	06/14/2013
<b>Decision Date:</b>	07/21/2015	<b>UR Denial Date:</b>	06/02/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/12/2015

### 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: Illinois, California, 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 43-year-old female who sustained an industrial injury on 6/14/13. Injury occurred while she was driving and a client pulled her hair forcefully sideways with immediate onset of neck and low back pain. Conservative treatment for the cervical spine to date included physical therapy, medications, and activity modification. The 1/5/15 cervical spine MRI impression documented multilevel cervical spondylosis with moderate central canal stenosis at C4/5 and C5/6, with multilevel variable foraminal stenosis, most severe to the left at C5/6. Findings documented spondylosis from C3 to C7. At C4/5, there was a broad-based posterior disc bulge with an eccentric central to right paracentral protrusive component which effaced the ventral CSF collar to abut and contour the underlying cervical spinal cord, consistent with moderate central canal stenosis. Facet arthrosis and uncovertebral spondylosis were presents with borderline bilateral foraminal stenosis. At C5/6, there was a broad-based posterior disc bulge/disc osteophyte complex effacing the ventral CSF collar to abut and contour the underlying cervical spinal cord, consistent with moderate central canal stenosis. Facet arthrosis and uncovertebral spondylosis were present with mild right and moderate to severe left foraminal stenosis. The 4/13/15 neurosurgical report cited constant neck pain shooting down both upper extremities, left greater than right, and into the 3rd through 5th digits with intermittent paresthesias in the same distribution. Pain was worse when she tilted her head to the right. Heat and ice improved the pain, and physical therapy gave her only mild improvement. Physical exam documented reasonable range of motion, negative Spurling's test, negative Hoffman's, toes downgoing, normal gait, and ability to heel and toe walk. Neurologic exam documented intact

strength, sensation, and reflexes. The 1/2/15 cervical spine MRI documented C5/6 kyphosis with stenosis and right hemicord compression, and stenosis at C4/5 and C6/7. The injured worker had failed conservative treatments and had a positive MRI. She would like consideration for artificial disc replacement at C5/6, and also at C6/7 and/or C4/5. A CT myelogram was recommended. The 5/11/15 cervical CT myelogram impression documented posterior disc and osteophytes from C3 to C7 most pronounced at C4/5 and C5/6 where it abutted the cord causing slight distortion of the cord at C5/6 but there was still a trace of fluid around the cord at each of these levels. There were degenerative changes in the uncovertebral and facet joints with neuroforaminal encroachment minimal left at C3/4, mild left and minimal right at C4/5, marked left and mild right at C5/6, and minimal left at C6/7. The 5/15/15 neurosurgical report cited worsening neck pain and radicular symptoms with headaches. The CT myelogram showed moderate degenerative disc disease, stenosis, and bilateral neuroforaminal narrowing at C5/6, moderate degenerative disc disease with stenosis and bilateral neuroforaminal narrowing at C4/5, and mild findings at C6/7. There was a discussion regarding the potential need for surgery at C4/5, C5/6, and C6/7, and anterior cervical discectomy and fusion versus artificial disc replacement. As there was no gross facet arthropathy, the recommendation was for C4/5 and C5/6 artificial disc replacement with the Mobi-C artificial disc. Authorization was requested for C4/5 and C5/6 artificial disc replacement and associated inpatient stay, one day. The 6/2/15 utilization review non-certified the request for C4/5 and C5/6 artificial disc replacement and associated inpatient one day length of stay as there was no guideline support for artificial disc replacement at more than one level and she had exclusionary criteria of multilevel cervical disease and facet arthritis.

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

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

**C4-C5 and C5-C6 artificial disc replacement:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 306. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back Chapter (online version).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back, Disc prosthesis.

**Decision rationale:** The California MTUS are silent regarding artificial disc replacement. The Official Disability Guidelines indicate that disc prostheses are under study. 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. 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. The general indications for currently approved cervical-ADR devices (based on protocols of randomized-controlled trials) are for patients 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. Guideline criteria have not been met. There is limited guidelines support for the use of cervical ADR with additional studies required to allow for a recommended status. This patient presents with multilevel cervical degenerative disc disease which fails to

meet the criteria of single level disease. Therefore, this request is not medically necessary

**Associated surgical services: Inpatient stay, one day:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Hospital Length of Stay Section.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back; Hospital length of stay (LOS).

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.