

<b>Case Number:</b>	CM15-0115929		
<b>Date Assigned:</b>	06/24/2015	<b>Date of Injury:</b>	09/03/2013
<b>Decision Date:</b>	07/24/2015	<b>UR Denial Date:</b>	06/09/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/16/2015

### 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:

This injured worker is a 34-year-old woman sustained an industrial injury on 9/3/13. Injury was reported relative to setting up her cosmetologist/esthetician work station. Past medical history was positive for Paget-von Schroetter disease and associated rib resection procedure. The 5/13/15 cervical spine MRI impression documented a 1 mm right lateral bulge in the annulus at C3/4 and hypertrophic change in the right uncovertebral joint and spondylosis with minimal attenuation of the distal right C4/5 lateral recess. This was a progressive findings compared to the 9/30/13 exam. At C4/5, there was a persistent 2 mm left paracentral disc protrusion which partially attenuated the proximal lateral recess without displacing the more laterally positioned ventral root. At C5/6, there was minimal disc desiccation with 2 mm bulge in the annular and minor spondylosis which partially attenuated the proximal and distal lateral recess. There was minimal left foraminal stenosis. The 5/28/15 orthopedic surgery report cited increased neck and upper shoulder pain. Cervical spine exam documented restricted range of motion, pain with axial compression, and generalized tenderness to palpation. There was 5-/5 left deltoid and left wrist extensor weakness, decreased sensation in the left thumb and index finger, negative Hoffman's, and normal upper extremity deep tendon reflexes. Shoulder range of motion was full. Gait and heel/toe walk were normal, and there was no clonus. MRI showed degenerative disc disease with foraminal stenosis at C4/5 and C5/6. Conservative treatment had been provided over 20 months with some temporary relief, but had ultimately failed. The treatment plan recommended C4-6 artificial disc replacement. The 6/2/15 authorization request cited increased neck and upper shoulder pain that prevented her from the physical demands of her job

and interfered with activities of daily living. She had completed a course of conservative treatment over the past 20 months that included physical therapy, injections, modified duty, and had been taken off work completely. Authorization was requested for C4-6 artificial disc replacement, pre-operative medical clearance to include chest X-ray, EKG, and labs, and post-operative physical therapy 2 times per week for 6 weeks (12 visits). The 6/9/15 utilization review non-certified the C4-6 artificial disc replacement and associated surgical requests as there was no documentation of images showing a neural compressive lesion to correlate with clinical examination.

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

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

#### **C4-6 artificial disc replacement: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints. 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 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. 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. 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. Currently, two-level cervical artificial disc replacement is not recommended by evidence based medical guidelines. Therefore, this request is not medically necessary.

#### **Pre-operative medical clearance: 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.

**Post-operative physical therapy x12: 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-operative medical clearance: 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.

**Pre-operative medical clearance: labs: 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.