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**Notice of Independent Medical Review Determination**

Dated: 12/5/2013

[REDACTED]

[REDACTED]

Employee:

Claim Number:

Date of UR Decision:

Date of Injury:

IMR Application Received:

MAXIMUS Case Number:

[REDACTED]

8/16/2013

11/15/2011

8/29/2013

CM13-0018259

- 1) MAXIMUS Federal Services, Inc. has determined the request for **C5-6, C6-1 diskectomy with instrumentation is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **pro disc C is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **pre op labs is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for **chest x-ray is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for **EKG is not medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for **physician's assistant is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/29/2013 disputing the Utilization Review Denial dated 8/16/2013. A Notice of Assignment and Request for Information was provided to the above parties on 10/11/2013. A decision has been made for each of the treatment and/or services that were in dispute:

- 1) MAXIMUS Federal Services, Inc. has determined the request for **C5-6, C6-1 diskectomy with instrumentation** is not **medically necessary and appropriate**.
- 2) MAXIMUS Federal Services, Inc. has determined the request for **pro disc C** is not **medically necessary and appropriate**.
- 3) MAXIMUS Federal Services, Inc. has determined the request for **pre op labs** is not **medically necessary and appropriate**.
- 4) MAXIMUS Federal Services, Inc. has determined the request for **chest x-ray** is not **medically necessary and appropriate**.
- 5) MAXIMUS Federal Services, Inc. has determined the request for **EKG** is not **medically necessary and appropriate**.
- 6) MAXIMUS Federal Services, Inc. has determined the request for **physician's assistant** is not **medically necessary and appropriate**.

### Medical Qualifications of the Expert Reviewer:

The independent Medical Doctor who made the decision has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Orthopedic Surgery, has a subspecialty in Spine Surgery and is licensed to practice in California. 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 treatments and/or services at issue.

### Expert Reviewer Case Summary:

50 year old male sustained an injury on 11/15/11. MRI cervical spine 2/6/12 with decreased disc height. C5/6 severe left and mild right neural foraminal narrowing. C6/7 with moderate left foraminal stenosis. Physical examination 11/20/12 demonstrates normal gait. 4/5 strength with wrist extensors, triceps, finger flexors, interossei, biceps, brachioradialis and triceps. Request for disc arthroplasty C5/6 and C6/7. Physical examination from 9/4/13 demonstrates decreased sensation to cold in left C6 distribution. Bone density documented as -1.8 on 7/23/13. Minimal improvement with cervical epidural steroid injection from 4/24/12.

### Documents Reviewed for Determination:

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- [REDACTED]

#### 1) Regarding the request for C5-6, C6-1 discectomy with instrumentation :

##### The Medical Treatment Guidelines Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the ODG (neck and upper back chapter); American Association of Orthopaedic Surgeons Position Statement Reimbursement of the First Assistant Surgery in Orthopaedics; (<http://circ.ahajournals.org/cgi/content/full/116/17/e418>), which is not part of MTUS.

The Expert Reviewer found that no section of the MTUS was applicable. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Expert Reviewer based his/her decision on the Official Disability Guidelines, Neck and Upper Back Chapter.

##### Rationale for the Decision:

The Official Disability Guidelines state 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. 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. The cervical disc was approved when used for FDA indications at a single level and with no contraindications. The North American Spine Society evidence-based clinical guideline for treatment of cervical radiculopathy due to degenerative disorders suggested fusion and ADR were comparable treatments in the short-term for single level disease. They also noted that anterior cervical decompression was comparable to anterior fusion, producing similar clinical outcomes in the treatment of single-level cervical radiculopathy from degenerative disorders. Based upon the guidelines above, the request for a cervical disc arthroplasty C5-C7 does not meet medical necessity. Cervical disc arthroplasty is recommended for single level disc disease. **The request for C5-6, C 6-1 discectomy with instrumentation is not medically necessary and appropriate.**

**2) Regarding the request for pro disc C:**

Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**3) Regarding the request for pre op labs:**

Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**4) Regarding the request for chest x-ray:**

Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**5) Regarding the request for EKG:**

Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**6) Regarding the request for physician's assistant:**

Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Effect of the Decision:**

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the final determination of the Administrative Director, Division of Workers' Compensation. With respect to the medical necessity of the treatment in dispute, this determination is binding on all parties.

In accordance with California Labor Code Section 4610.6(h), a determination of the administrative director may be reviewed only if a verified appeal is filed with the appeals board for hearing and served on all interested parties within 30 days of the date of mailing of the determination to the employee or the employer. The determination of the administrative director shall be presumed to be correct and shall be set aside only upon proof by clear and convincing evidence of one or more of the grounds for appeal listed in Labor Code Section 4610.6(h)(1) through (5).

Sincerely,

Paul Manchester, MD, MPH  
Medical Director

cc: Department of Industrial Relations  
Division of Workers' Compensation  
1515 Clay Street, 18<sup>th</sup> Floor  
Oakland, CA 94612

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Disclaimer: MAXIMUS is providing an independent review service under contract with the California Department of Industrial Relations. MAXIMUS is not engaged in the practice of law or medicine. Decisions about the use or nonuse of health care services and treatments are the sole responsibility of the patient and the patient's physician. MAXIMUS is not liable for any consequences arising from these decisions.