

Case Number:	CM13-0016510		
Date Assigned:	06/11/2014	Date of Injury:	08/09/2010
Decision Date:	07/14/2014	UR Denial Date:	07/30/2013
Priority:	Standard	Application Received:	08/26/2013

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. The expert reviewer is Board Certified in Orthopedic Surgery and is licensed to practice in Oklahoma, Texas, California, and Tennessee. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 32-year-old male who reported an injury to his low back on 08/09/10. The clinical note dated 03/27/13 indicates the injured worker complaining of lumbosacral pain. The injured worker rated the pain as 3/10. The clinical note dated 04/26/13 indicates the injured worker also having complaints of tenderness and palpable spasms over the paravertebral musculature. The injured worker also demonstrated decreased range of motion. There is an indication the injured worker has a positive straight leg raise at 90 degrees on the right. Increased pain was identified with heel and toe walking. The clinical note dated 05/30/13 indicates the injured worker rating his pain as 5/10. The injured worker also reported difficulty sleeping at night secondary to the low back complaints. The injured worker has been prescribed the use of Gabapentin, Dendracin lotion, and Anaprox for pain relief. The clinical note dated 06/06/13 indicates the injured worker continuing with radiating pain from the low back into both lower extremities. The note indicates the injured worker having previously undergone two epidural steroid injections which did provide temporary relief. The injured worker also reported tingling in the lower extremities. There is an indication the injured worker has previously undergone an MRI (magnetic resonance imaging) which revealed multiple lumbar disc herniations, most significantly at L4-5. The clinical note dated 06/24/13 indicates the injured worker able to demonstrate 50 degrees of lumbar flexion, 18 degrees of extension, 19 degrees of left lateral bending, and 20 degrees of right lateral bending. The electrodiagnostic studies completed on 06/17/13 revealed an active L5 denervation. The clinical note dated 07/31/13 indicates the injured worker having previously undergone acupuncture treatments which did produce a reduction in pain on a temporary basis.

IMR ISSUES, DECISIONS AND RATIONALES

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

INPATIENT LENGTH OF STAY (LOS) 2 DAYS: 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 CHAPTER, HOSPITAL LENGTH OF STAY (LOS).

Decision rationale: The request for an inpatient stay at two days is not medically necessary. Given the lack of medical necessity of the requested surgery, the additional request for a two day inpatient stay is rendered not medically necessary.

LUMBAR L4-L5 ARTIFICIAL DISC REPLACEMENT: 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 CHAPTER, DISC PROSTHESIS.

Decision rationale: The request for a lumbar L4-5 artificial disc replacement is not medically necessary. The documentation indicates the injured worker complaining of low back pain with radiating pain into the lower extremities. According to the Official Disability Guidelines (ODG), no high quality studies have recently been published in peer reviewed literature supporting the safety and efficacy of the use of artificial disc replacements in the lumbar region. There is an indication that artificial disc replacements may be appropriate; however, given that no high quality studies have been completed fully supporting the safety and efficacy of the use of artificial disc replacements in the lumbar region, this request is not fully indicated. Additionally, it should be made clear that long term studies have not been made available supporting the use of artificial disc replacements in the lumbar region. Given these factors, this request is not indicated as medically necessary.