

Case Number:	CM13-0026773		
Date Assigned:	12/04/2013	Date of Injury:	09/30/2008
Decision Date:	02/28/2014	UR Denial Date:	09/09/2013
Priority:	Standard	Application Received:	09/20/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Orthopedic 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 physician 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 patient is a 38-year-old male who reported an injury on 09/30/2008. The patient is diagnosed with lumbar radiculitis, spinal stenosis, and lumbar surgery on 12/21/2010. The patient was seen by a physician on 09/20/2013. The patient reported persistent lower back pain with activity limitation. Physical examination revealed decreased forward flexion. Treatment recommendations included a stress echo for cardiology clearance, and a referral to a primary medical doctor for re-management of blood sugar prior to surgery.

IMR ISSUES, DECISIONS AND RATIONALES

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

L4-L5 Anterior 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), Low Back Chapter, Disc prosthesis

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Disc Prosthesis

Decision rationale: California MTUS/ACOEM Guidelines state surgical consultation is indicated for patients who have severe and disabling lower extremity symptoms; activity

limitations due to radiating pain for more than 1 month; extreme progression of symptoms; clear clinical, imaging, and electrophysiological evidence of a lesion that has been shown to benefit from surgical repair; and a failure of conservative treatment. Official Disability Guidelines state disc prosthesis is not recommended. While artificial disc replacement as a strategy for treating degenerative disc disease has gained substantial attention, it is not possible to draw any positive conclusions concerning its effect on improving patient outcomes. The patient has been previously treated with epidural injections, medications, therapy, and activity modification. The patient also underwent an EMG/NCV study on 03/01/2011, which indicated radiculopathy. While the patient has been previously authorized to undergo an L5-S1 anterior decompression and fusion with instrumentation, the request for L4-5 anterior disc replacement is not indicated. Official Disability Guidelines state indications for a lumbar artificial disc replacement include, among other factors, primary back pain and/or leg pain in the absence of nerve root compression with single level disease. Based on the clinical information received, the request is non-certified.

A Cold Therapy Unit: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Blue Cross/Blue Shield Medical Policy, Cold and/or compression therapy.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-300, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG,) Low Back Chapter, Cold/Heat Packs.

Decision rationale: California MTUS/ACOEM Practice Guidelines state physical modalities have no proven efficacy in treating acute low back symptoms. At home, local applications of heat or cold are as effective as those performed by therapists. As the patient's surgical procedure has not been authorized, the current request for a cold therapy unit cannot be determined as medically necessary. Additionally, there is no indication as to why this patient would not benefit from at-home, local applications of cold packs as opposed to a motorized unit. Based on the clinical information received, the request is non-certified.