

Case Number:	CM13-0048110		
Date Assigned:	12/27/2013	Date of Injury:	11/13/2010
Decision Date:	06/03/2014	UR Denial Date:	10/16/2013
Priority:	Standard	Application Received:	11/04/2013

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 Neurosurgery, and is licensed to practice in Texas, New Mexico, Maryland, New York, California, Colorado, Georgia, Louisiana, Minnesota, Missouri, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Virginia, Nevada, Illinois, and Kentucky. 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 36 year old male firefighter who sustained a lifting injury to the low back on 11/13/10. He complains of low back pain and left leg pain. He has been treated conservatively with physical therapy, medications, and epidural steroid injections without resolution of symptoms. An MRI of the lumbar spine dated 12/8/12 showed L4-5 mild loss of disc signal with 3mm central disc bulge, and moderate facet hypertrophy which minimally narrows the canal without focal nerve root impingement. There is a 4-5mm left foraminal protrusion with slight cephalad extension that mild-to moderately narrows the left neuroforamen, and a 4-5mm right foraminal and far lateral protrusion with partial annular tear mildly narrowing the distal right neuroforamen without obvious nerve root impingement. At L5-S1, there is moderate loss of disc height and signal intensity with a 5-6mm left central protrusion with partial annular tear which mildly flattens the anterior thecal sac, left side slightly greater than right without obvious nerve root impingement. There is mild facet hypertrophy without overall canal stenosis. There is also a 4-5mm disc bulge extending into the left neuroforamen with facet hypertrophy and loss of disc height mildly to moderately narrowing the left neuroforamen. A 3mm right sided disc bulge mildly narrows the right neuroforamen without nerve root impingement. The injured worker was seen for second surgical opinion on 5/20/13. He presented with complaints of constant low back pain with intermittent pain that travels down the left lower extremity with some left foot numbness. The injured worker reported that he has had some temporary benefit from physical therapy and epidural steroid injections, but the pain has consistently returned. On physical examination, the injured worker's lumbar range of motion was severely limited in forward flexion with exacerbation of pain. lumbar extension is better, but he still has pain. Motor strength

was 5/5 throughout the bilateral lower extremities. Sensation was decreased in the left S1 distribution. He has absent ankle jerk.

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, L5-S1 ANTERIOR DISCECTOMY AND FUSION WITH INSTRUMENTATION: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305, 310. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-306, 310. Decision based on Non-MTUS Citation Official Disability Guidelines.

Decision rationale: Current evidence-based guidelines do not recommend total disc arthroplasty in the lumbar spine. Per ACOEM guidelines, lumbar fusion is not supported in the absence of fracture, dislocation, complications of tumor, or infection. While the injured worker does have evidence of degenerative disc disease, there is no evidence of motion segment instability at any level of the lumbar spine. It should be noted that there have been no clinical trials regarding the efficacy of "hybrid" procedures with artificial disc replacement at one level and fusion at an adjacent level. As such, the request is not medically necessary.

POSSIBLE BMP, ALLOGRAFT, OSTCOCELL: 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.

PREOPERATIVE EVALUATION AND CLEARANCE: 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.

POSTOPERATIVE PHYSICAL THERAPY, 18 SESSIONS: 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.

HOSPITAL STAY TWO TO THREE (2-3) DAYS: 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.

HOME HEALTH NURSE FOR WOUND ASSESSMENT: 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.

ICE MACHINE: 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.

LUMBAR CORSET OR BRACE: 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.