

<b>Case Number:</b>	CM14-0004527		
<b>Date Assigned:</b>	02/05/2014	<b>Date of Injury:</b>	12/22/2010
<b>Decision Date:</b>	07/10/2014	<b>UR Denial Date:</b>	12/31/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/13/2014

### 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 Surgeon 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 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 56-year-old male who reported an injury on 12/22/2010 after he was pulling on a Brussels sprout plant. The injured worker reportedly sustained an injury to his entire back. The injured worker's treatment history included activity modification, assisted ambulation, multiple medications, physical therapy, chiropractic care, medial branch blocks, a right sacroiliac joint injection, and left shoulder surgery. The injured worker underwent an electrodiagnostic study on 08/02/2011 that did not reveal any abnormalities. The injured worker has a complicated medical history, which included psychiatric overlay. The injured worker was treated with psychiatric therapy. The injured worker underwent an MRI on 06/12/2013 that concluded there was a disc bulge at the L4-5, no definitive nerve root impingement, and chronic degenerative disc disease at the L5-S1 with nerve root abutment but not definitive nerve root impingement. The injured worker was evaluated on 12/09/2013. It was documented that the injured worker had a markedly antalgic gait assisted with a cane. It was documented that there were no obvious motor or neurological deficits and polydermatomal right-sided L4, L5, and S1 hypoesthesia with limited range of motion of the lumbar spine. It was noted that the injured worker had at least 3 to 4 Waddell's findings. The injured worker's diagnoses included chronic pain, L5-S1 spondylosing degenerative disc disease, cervical discopathy, and chronic narcotic use. The injured worker's treatment plan included lumbar total disc replacement and lumbar fusion with preoperative psychological and medical clearance.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**PRE-OPERATIVE PSYCHOLOGY EVALUATION AND CLEARANCE WITH PSYCHOLOGIST [REDACTED]: 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 ANTERIOR APPROACH CONSULTATION AND EVALUATION WITH [REDACTED]: 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.

**NORCO:** 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.

**L5-S1 ANTERIOR LUMBAR INTERBODY FUSION WITH PROSTHESIS,BASIC METABOLIC PANEL(BMP), ANT PLATING: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308-310.

**Decision rationale:** The requested L5-S1 anterior lumbar interbody fusion with prosthetic, basis metabolic panel, and ant plating is not medically necessary or appropriate. The American College of Occupational and Environmental Medicine recommends fusion surgery for patients who have evidence of instability that significantly impairs their function. The clinical documentation submitted for review does indicate that the injured worker has findings of

radicular symptoms. However, there is no evidence of significant instability that would require fusion surgery. Additionally, the physical findings of radiculopathy within the injured worker's most recent clinical examination are not supported by the imaging study or the injured worker's most recent electrodiagnostic study. There is no evidence of significant impingement of the nerve roots that would cause the subjectively reported radicular symptoms. As such, the requested L5 anterior lumbar interbody fusion with prosthesis, basic metabolic panel (BNP), and ant plating is not medically necessary or appropriate.

**ASSISTANT SURGEON- [REDACTED]: 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.

**L4-5 PRODISC L TDR (TOTAL DISC REPLACEMENT): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**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 requested L4-5 ProDisc lumbar total disc replacement is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not address this surgical intervention. Official Disability Guidelines do not recommend total disc replacement in the lumbar region. Official Disability Guidelines classify this surgical intervention as highly investigational and not supported by scientific evidence. There are no exceptional factors noted within the documentation to support extending treatment beyond guideline recommendations. As such, the requested L4-5 ProDisc lumbar total disc replacement is not medically necessary or appropriate.

**FRONT WHEEL WALKER AND RAISED TOILET SEAT: 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.

**CARDIAC-THORACIC UNIT (CTU): 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 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.