MAXIMUS Federal Services

Case Number:	CM14-0131305		
Date Assigned:	08/20/2014	Date of Injury:	02/04/2002
Decision Date:	09/18/2014	UR Denial Date:	07/18/2014
Priority:	Standard	Application Received:	08/15/2014

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 Orthopaedic 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 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:

This 52-year-old female linen materials checker/sorter sustained an industrial injury on 2/4/02. Injury occurred while counting pieces of clothing. The patient was off work in 2005 for 4 months but improved with conservative treatment and returned to work. The 1/31/12 lumbar spine MRI impression documented posterior disc protrusion/extrusion at L4/5 and L5/S1 with annular tear/fissure and facet arthropathy. There was traversing nerve root compromise at L4/5 on the right and exiting nerve root compromise bilaterally at L4/5 and L5/S1. There was decreased disc height at L4/5 by 70% as compared to L3/4 and L5/S1. The 5/9/14 treating physician narrative report cited constant moderate lower back pain with occasional minimal to slight pain radiating into the left leg and occasional minimal numbness in the S1 distribution. Back pain was worsened with repetitive bending, heavy lifting, stooping, very prolonged sitting, and twisting. Physical exam findings documented mild loss of lumbar range of motion with moderate pain, L4/5 ligamentous tenderness, minimal to slight left sacroiliac joint tenderness, 5/5 bilateral lower extremity strength, normal deep tendon reflexes and sensation, and negative mechanical and nerve tension signs. Lumbar spine x-rays revealed evidence of disc space narrowing at L4/5. The patient had been followed for the past 8 years with on-going low back and left leg pain. Treatment included multiple cortisone injections, lower back brace, anti-inflammatory medications, acupuncture, physiotherapy, and home exercises. She had failed conservative treatment. The patient was tired of living with on-going lower back pain and had significant disc abnormality at L4/5 that was worsening. Surgery was recommended to include L4/5 and L5/S1 anterior approach artificial disc replacement. The patient was to continue working with work restrictions as prescribed. The 7/18/14 utilization review denied the artificial lumbar disc replacement and associated requests as this surgery was considered experimental and was not the standard of care.

IMR ISSUES, DECISIONS AND RATIONALES

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

Artificial lumbar disc replacement L4-L5 and L5-S1 anterior approach with an anterior approach access surgeon: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints,Chronic Pain Treatment Guidelines Surgical Considerations. Decision based on Non-MTUS Citation ODG Low Back.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 219-220. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic, Disc prothesis.

Decision rationale: The ACOEM Revised Low Back Disorder guidelines state that artificial disc replacement (ADR) is not recommended as a treatment for chronic non-specific lower back pain or any other spinal pain syndrome. The Official Disability Guidelines, updated 8/22/14, do not recommend ADR. Current US treatment coverage recommendations were listed. Indications for lumbar ADR include primary back and/or leg pain in the absence of nerve root compression with single level disease. Patients exclusions also include spondylolisthesis, stenosis, facet mediated pain, and osteoporosis. FDA approved indications are listed as failure of 6 months non-operative treatment, skeletally mature patient, single disc only, no infection, no sensitivity to implant materials, and no osteoporosis or spondylosis. Guideline criteria have not been met. This patient presents with two-level disc disease with evidence of nerve root compression at both levels. There is no detailed documentation that recent comprehensive pharmacologic and non-pharmacologic conservative treatment had been tried and failed. Guidelines also do not support the request. Therefore, this request is not medically necessary.

Pre-op internal medicine evaluation: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation www.guideline.gov/content.aspx?id=38289.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Practice advisory for preanesthesia evaluation: an updated report by the American Society of Anesthesiologists Task Force on Preanesthesia Evaluation. Anesthesiology 2012 Mar; 116(3):522-38.

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

Post-op lumbar brace TLSO: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Low Back/Back brace, post operative (fusion).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 138-139.

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

Physical therapy- Quantity: 12 (post-op physiotherapy (2 times a week for 6 weeks)): Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 25.

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