

Case Number:	CM14-0038790		
Date Assigned:	06/27/2014	Date of Injury:	03/04/2013
Decision Date:	08/05/2014	UR Denial Date:	03/01/2014
Priority:	Standard	Application Received:	04/02/2014

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 Surgery and is licensed to practice in Texas, Tennessee and Montana. 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 39-year-old male who reported an injury on 08/23/2013. The mechanism of injury was a motor vehicle accident. The prior treatments included epidural steroid injections. The injured worker underwent an MRI of the lumbar spine without contrast on 08/23/2013 which revealed large extruded discs at L4-5 with lumbar spinal canal stenosis at L4-5. The injured worker subsequently underwent an MRI of the lumbar spine on 02/15/2014 with and without contrast which revealed there was no lumbar compression deformity and no listhesis. At the level of L4-5, there was desiccation and central protrusion with an annular tear. There were congenitally short pedicles and hypertrophy of the facet joints and ligamentum flavum with mild to moderate central stenosis and moderate right and mild to moderate left lateral recess compromise. There was a small 4 mm synovial cyst along the posterior aspect of the left L4-5 facet joint. The injured worker's physical examination dated 11/21/2013 revealed the injured worker's prior treatment included medications, back brace, TENS unit, and 6 sessions of physical therapy. The physical examination, neurologic examination revealed the injured worker had motor strength of 5/5 with decreased sensations to light touch and pinprick over the bilateral L4, L5, and S1 distributions. The straight leg raise test was positive bilaterally. The injured worker was unable to stand erect secondary to leg pain. If the injured worker flexed forward, his leg pain was relieved but his back pain was worse. The physician reviewed the injured worker's MRI and opined that the injured worker had moderate to severe central canal stenosis. The diagnostic impression included L4-5 disc collapse with posterior disc protrusion and moderate to severe central canal stenosis. The physician opined that the treatment should include a total disc arthroplasty due to the demands of the injured worker's vocation. The subsequent examination dated 04/24/2014 revealed the injured worker's physical examination remained the same. The treatment plan again included a total disc arthroplasty.

IMR ISSUES, DECISIONS AND RATIONALES

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

L4-L5 total disc arthroplasty with a 2 day inpatient stay: 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), Treatment Index, 12th Edition (web), 2014, Low back, Disc prosthesis.

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

Decision rationale: The ACOEM Guidelines indicate that surgical consultations may be appropriate for injured workers who have severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies, preferably with accompanying objective signs of neural compromise. There should be documentation of activity limitations due to radiating leg pain for more than 1 month or extreme progression of lower leg symptoms. There should be documentation of clear clinical, imaging, and electrophysiological evidence of a lesion that has been shown to benefit in both the short and long-term from surgical repair, and a failure of conservative treatment to resolve disabling radicular symptoms. The ACOEM Guidelines indicate that there is no good evidence that spinal fusion alone is effective for treating any type of acute low back pain in the absence of spinal fracture, dislocation, or spondylolisthesis unless there is instability and motion in the segment operated on. The clinical documentation submitted for review indicated the injured worker had mild to moderate central canal stenosis at the level of L4-5. The physical examination revealed dermatomal findings of decreased sensation at L4, L5, and S1 bilaterally. However, there was a lack of documentation of instability for the requested level on flexion and extension x-rays. There was a lack of electrodiagnostic studies. The CA MTUS ACOEM Guidelines do not specifically address patient hospital stays. The ODG indicate that hospital length of stay for a lumbar fusion is 3 days. However, as the total disc arthroplasty was not supported, this portion of the request would not be supported. Given the above, the request for L4-L5 total disc arthroplasty with a 2 day inpatient stay is not medically necessary.