

Case Number:	CM14-0196135		
Date Assigned:	12/04/2014	Date of Injury:	09/01/2010
Decision Date:	01/16/2015	UR Denial Date:	11/14/2014
Priority:	Standard	Application Received:	11/24/2014

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 Georgia and North Carolina. 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 44-year-old male who reported an injury on 09/01/2010 due to cumulative trauma. On 10/15/2014, the injured worker presented with ongoing low back pain with radiation of pain along the bilateral lower extremities to the feet. The injured worker failed to respond to a prior lumbar epidural steroid injection performed on 08/23/2014 at the L5-S1 level. Current medications included Voltaren and hydrocodone. Examination of the lumbar spine noted tenderness to palpation elicited over the mid thoracic and lower lumbar spine with evidence of 3+ hypertonicity noted. Range of motion is limited by pain and spasm in all directions. There is a positive bilateral straight leg raise and a positive bilateral Kemp's test noted. Diagnoses were L5-S1 disc protrusion with right angular tear and L4-5 disc protrusion on left with encroachment of the L5-S1 nerve roots per MRI, lumbar sprain/strain, and low back syndrome. An official MRI dated 04/05/2014 noted a right paracentral annular fissure and 1 mm bulge. The provider recommended a total disc arthroplasty at the L5-S1 level. The provider's rationale was not provided. The Request for Authorization form was dated 11/06/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Total disc arthroplasty at the L5-S1 level: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back

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

Decision rationale: The request for a total disc arthroplasty at the L5-S1 level is not medically necessary. The California MTUS/ACOEM Guidelines state that a surgical consultation is indicated for patients who have severe disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies preferably with accompanying objective signs of neural compromise, activity limitation due to radiating leg pain, clear clinical imaging and electrical physiologic evidence of a lesion that has been shown to benefit in both the short and long term from surgical repair, and failure of conservative treatment to resolve disabling radicular symptoms. The Official Disability Guidelines further state that a total disc arthroplasty at the L5-S1 level 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 conclusion concerning its effect on improving patient outcomes. Studies have failed to demonstrate superiority of disc replacement over lumbar fusion which is also not a recommended treatment in ODG for degenerative disc disease. The injured worker's examination reveals tenderness to palpation of the mid thoracic and lower lumbar spine with a positive bilateral Kemp's and straight leg raise. There is also a limited range of motion due to pain and spasm. There is no information on an official imaging study submitted for review. There is also no information on previous treatments the injured worker underwent and the efficacy of those treatments. The provider noted a prior epidural steroid injection that the injured worker was unresponsive to. However, the Official Disability Guidelines does not recommend a total disc arthroplasty. There is a lack of exceptional factors in the documentation submitted to support approving outside of the guideline recommendations. As such, medical necessity has not been established.

Pre-op medical 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.

Post op physical therapy qty: 12: 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.

1-3 day inpatient hospital stay: 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.