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| Case Number: | CM14-0068077 | | |
| Date Assigned: | 07/11/2014 | Date of Injury: | 06/24/2013 |
| Decision Date: | 01/02/2015 | UR Denial Date: | 04/30/2014 |
| Priority: | Standard | Application Received: | 05/12/2014 |

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 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 36 year old male who sustained a work related injury June 24, 2013. Past medical history included diagnoses of; asthma, migraines, lumbosacral spondylosis without myelopathy, displaced lumbar intervert disc without myopathy, thoracic/lumbosacral neuritis/radiculitis unspecified. On April 17, 2014, the injured worker presented to the pain management physician for follow-up consultation. He complains of low back and leg pain with an increase since April 12, 2014 when he felt a pop getting into bed in his right lower back, with radiation to the right anterior and medial thigh and anterior and medial leg. There was mild numbness in the same distribution but no incontinence or weakness. He did go to urgent care who prescribed Neurontin which caused a dissociative state, Nucynta which was ineffective for pain, and Dilaudid, with mild to moderate pain reduction and no side effects. The pain is constant and described as throbbing, shooting, stabbing, hot /burning, and aching and rated on average as 9/10. Past treatment includes; NSAID's, anti-inflammatory agents, ibuprofen, muscle relaxants, Flexeril, Vicodin, Epidural Steroid Injections x 2, ultrasound, heat, cold, and lumbar traction. On examination; lumbar spine range of motion anterior flexion 40 degrees with pain, extension spine 15 degrees with pain, left and right lateral extension 10 degrees with pain and pain with rotation, left and right motor strength 5/5, deep tendon reflexes left and right patellar 1+, left Achilles 2+ and right Achilles absent, and straight leg raise right and left normal at 90 degrees. The physician documents the diagnoses as; thoracic/lumbosacral neuritis/radiculitis unspecified, lumbosacral spondylosis without myelopathy, lumbar intervert disc without myelopathy. Recommendations to stop the Neurontin, Dilaudid for pain, finish Medrol pack, await authorization for possible lumbar disc replacement surgery. On April 18, 2014, the primary treating physician documents that physical therapy notes dated March 28, 2014, reveals no significant improvement in pain or symptoms however report benefits from moving/exercising in

therapy. The spinal surgeon is awaiting authorization for surgery and recommends more therapy. There is noted atrophy and numbness in the right and left leg intermittently with numbness and intermittent tingling of the feet. The diagnoses is documented as low back pain, degenerative disc disease at L1-L5, left L4-5 disc bulge, s/p Epidural Steroid Injection on 9/6/2013 and 1/3/2014. Recommendations documented as discogram L1-S1 prior to surgery and repeat Epidural Steroid Injection at L3-L5. According to utilization review performed April 30, 2014, pain management evaluation of 3/6/2014 indicated a normal lower extremity neurological evaluation. A recommendation was made 3/21/2014, for another Epidural Steroid Injection and a discogram, with no documented results. The medical record implicates multiple levels of degenerative change rather than single level. Therefore the guidelines do not recommend lumbar disc replacement and is non-certified. As the request for artificial disc replacement is non-certified, the requests for; 2-3 night stay, pre-op medical clearance including chest x-ray, EKG, and labs, and post-operative physical therapy 2 x 6, is not medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

Artificial Disc Replacement at L4-5: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Low Back, Disc prosthesis.

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, Disc prosthesis

Decision rationale: CA MTUS/ACOEM is silent on the issue of disc arthroplasty. According to the ODG, Low Back, Disc prosthesis, it is not recommended. It states, "While artificial disc replacement (ADR) as a strategy for treating degenerative disc disease has gained substantial attention, it is not possible to draw any positive conclusions concerning its effect on improving patient outcomes. The studies quoted below have failed to demonstrate superiority of disc replacement over lumbar fusion, which is also not a recommended treatment in ODG for degenerative disc disease. As lumbar disc arthroplasty is not medically necessary.

Associated surgical service: 2-3 night stay: 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); Low Back

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.

Associated surgical service: Pre-operative medical clearance, including chest x-ray, EKG & labs: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.guideline.gov/content.aspx?id=38289> and Official Disability Guidelines (ODG) Low Back, Preoperative testing, general

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.

Associated surgical service: Post-operative physical therapy 2x/week x 6 weeks: Upheld

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

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.