

Case Number:	CM15-0000440		
Date Assigned:	01/12/2015	Date of Injury:	06/06/2013
Decision Date:	03/20/2015	UR Denial Date:	12/10/2014
Priority:	Standard	Application Received:	01/02/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: Texas
 Certification(s)/Specialty: Orthopedic Surgery

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 06/06/2013 due to an unknown mechanism of injury. The injured worker reportedly sustained an injury to his right foot, leg, and hand. The injured worker's diagnoses included shoulder joint pain, a sprain of the hip and thigh, lumbago, sprain of the ankle, pain in the thoracic spine, joint pain of the upper arm, cervicgia, neuralgia/neuritis, backache, lumbosacral neuritis, and spondylolisthesis. The injured worker's treatment history included medications, physical therapy, and epidural steroid injections. The injured worker attended an office visit on 10/27/2014. However, no physical examination was provided during that visit. The injured worker's treatment recommendations included x-ray studies and MRI studies. Surgical intervention was recommended in the form of an L5-S1 artificial disc replacement with an L4-5 anterior interbody fusion. This request was reviewed and received an adverse determination due to a lack of MRI studies provided to support the surgical request. It was also noted that there was no justification provided to support artificial disc replacement over more traditional fusion surgery. A Letter of Appeal dated 01/06/2015 indicated that artificial disc replacement was FDA approved and should be considered to provide complete treatment to the injured worker. The injured worker was evaluated again on 12/12/2014. It was documented that the injured worker had undergone an MRI on 02/17/2014 that revealed a disc bulge at the L4-5. It was documented that the injured worker had undergone an x-ray of the lumbar spine on 12/03/2014 that indicated a retrolisthesis of the L5-S1 with disc space narrowing at the L4-5. The injured worker's examination at this appointment revealed decreased range of motion of the lumbar spine secondary to pain,

weakness of the left tibialis anterior, left gastrocnemius, left hamstring, and left peroneal tendons. The injured worker had a positive left sided straight leg raise test. The injured worker's treatment plan at that appointment included an L4-5 artificial disc replacement and L5-S1 anterior interbody fusion. The injured worker underwent an MRI on 02/27/2014. The results included mild diffuse disc bulging at the L4-5 with mass effect on the exiting L4 nerve root. A Request for Authorization was submitted on 12/03/2014 to support the request.

IMR ISSUES, DECISIONS AND RATIONALES

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

L4-L5 artificial 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). Low Back Procedure Summary

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

Decision rationale: The requested L4-5 artificial disc replacement is not medically necessary or appropriate. The American College of Occupational and Environmental Medicine recommend spinal surgery for patients who have significant radicular symptoms that have failed to respond to conservative treatment that are consistent with pathology identified on imaging studies. The clinical documentation submitted for review does indicate that the injured worker has left sided radicular symptoms that interfere with his ability to perform normal job duties. It is noted that the injured worker had pathology identified both on an MRI and x-ray studies. Official Disability Guidelines do not recommend artificial disc replacement for the lumbar spine. The clinical documentation submitted for review does not provide justification for artificial disc replacement over more traditional spinal fusion. As such, the requested L4-5 artificial disc replacement is not medically necessary or appropriate.