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| Case Number: | CM15-0187773 | | |
| Date Assigned: | 10/06/2015 | Date of Injury: | 09/13/2013 |
| Decision Date: | 11/18/2015 | UR Denial Date: | 09/03/2015 |
| Priority: | Standard | Application Received: | 09/24/2015 |

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: New York, Montana, California
 Certification(s)/Specialty: Neurological 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 36 year old male, who sustained an industrial injury on 9-13-13. The injured worker was diagnosed as having L5-S1 discogenic low back pain syndrome with herniation and annular tear; lumbar radiculopathy; L5-S1 annular tear; transitional lumbar anatomy. Treatment to date has included physical therapy (x16); chiropractic therapy (x3); back brace; epidural steroid injections lumbar (3-16-15); medications. Diagnostics studies included MRI lumbar spine (10-16-13). Currently, the PR-2 notes dated 8-6-15 indicated the injured worker was referred to this office complaining of low back pain with associated radiating pain to both legs. The pain radiates all the way into knee level along with posterior aspect. He reports tingling sensation but this has an "intermittent character". The provider documents "this has been going on for two years. The patient has been unable to return to work. Two separate courses of physical therapy, chiropractic care, and two recent epidural steroid injections have been ineffective. He continues to deteriorate. He has been out of work for an extended duration and at this point, the patient has no ability to go back to work because of the ongoing pain syndrome. He has tried multiple types of oral medication and is currently seeing a pain management physician who is prescribing Norco, Tizanidine and Mobic with limited benefit." On physical examination, the provider documents "sensory revealed no motor or sensory deficits. Normal reflexes - no Hoffmann, sensation is unchanged, sensation in torso is normal. Some diminished sensation in the distal parts of both feet. There is no apparent muscle atrophy, although straight leg raising is bilateral, is seemingly more pronounced on the left side. Most of the pain is in the lumbosacral area. His AROM is reduced by 50% with pain at end ranges. He has marked pain to

palpation of the L5-S1 spinous processes and paraspinal muscles with hypertonicity." The provider reviews a MRI of the lumbar spine dated 10-16-13 and documents "personally reviewed and are consistent with degenerative disc disease at multiple levels. However, the most significant finding is disc degeneration and herniation of the disc around 6-7mm centrally at L5-S1 with a broader tear and bilateral lateral recess stenosis. The other discs L4-L5 and L3-L4, show some degeneration, although no significant canal compromise. Facet arthropathy is present at all three levels bilaterally." The provider's treatment plan includes a request for a "L5-S1 arthroplasty which will preserve of motion at the segment." A Request for Authorization is dated 9-21-15. A Utilization Review letter is dated 9-4-15 and non-certification for an Arthroplasty at L5-S1 (ALIF) and associated services. A request for authorization has been received for an Arthroplasty at L5-S1 and associated services.

IMR ISSUES, DECISIONS AND RATIONALES

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

Arthroplasty at L5-S1: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter-Disc Prosthesis.

Decision rationale: The California MTUS guidelines recommend lumbar surgery if there is severe persistent, debilitating lower extremity complaints, clear clinical and imaging evidence of a specific lesion corresponding to a nerve root or spinal cord level, corroborated by electrophysiological studies which is known to respond to surgical repair both in the near and long term. Documentation does not provide this evidence. The provider notes the patient complains of pain down to his knees and yet recommends a disc arthroplasty for L5-S1. ODG guidelines do not recommend a lumbar disc prosthesis. The requested treatment: Arthroplasty at L5-S1 is not medically necessary and appropriate.

Associated surgical service: Inpatient stay x 3 days: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

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.

Pre-op Medical work up: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, Chapter 7: Independent Medical Examinations and Consultations, page 127.

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 Aquatic therapy 3 x 6: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Aquatic therapy.

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: Lumbar brace: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004.

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.