

<b>Case Number:</b>	CM15-0191644		
<b>Date Assigned:</b>	10/05/2015	<b>Date of Injury:</b>	01/13/2012
<b>Decision Date:</b>	11/24/2015	<b>UR Denial Date:</b>	09/21/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/29/2015

### 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: California

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 39-year-old male who sustained an industrial injury on 1-13-2012. Diagnoses have included lumbar disc displacement without myelopathy, retrolisthesis, acute lumbar radiculopathy, lumbar disc narrowing, lumbar disc disease, facet arthropathy, degeneration of lumbar intervertebral disc, and low back pain at multiple sites. Diagnostic tests include a lumbar spinal X-ray on 8-3-2015 showing upper right and lower left lumbar scoliosis, bilateral L5-S1 facet joint arthrosis and hypertrophy, severe L5-S1 disc space narrowing, worsening retrolisthesis at L5-S1, and worsening anterior disc space narrowing at L5-S1. MRI lumbar spine from 2/4/15 demonstrates dessication of the L4-5 disc with minimal bulging. At L5-S1 demonstrates 5 mm borad based protrusion slightly impinging on the thecal sac. Minimal encroachment of the foramen is noted. An EMG performed 8-7-2015 was interpreted as "abnormal" and consistent with acute left lumbar radiculopathy at L5. Documented treatment has included physical therapy, chiropractic treatments, and TENs unit all noted to provide temporary relief, lumbar epidural steroid injections noted to last 4-6 months, and medication. The injured worker was seen for a surgical consult, and on 9-9-2015 the treating physician stated "no further conservative or nonsurgical treatment will improve his lumbar radiculopathy." The injured worker continues to complain of chronic "shooting and stabbing" low back pain radiating to the left leg noted 6-17-2015 to be 60 percent back pain and 40 percent leg pain. He has been receiving help from family with activities of daily living. He also reported loss of urine and bowel control, and symptoms become worse with stationary positioning, transferring, and upon movement. The treating physician's plan of care includes L4-L5 artificial disc replacement; L5-S1 anterior fusion with interbody fixation, and associated services which was denied on 9-21-2015. The injured worker has not been working.

## 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/total disc replacement:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) ([http://www.odg-twc/odgtwc/low\\_back.htm](http://www.odg-twc/odgtwc/low_back.htm)), ACOEM Low Back Disorders, Revised 2007, pages 209-211.

**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." In this case there is no evidence of any surgically treatable lesion or instability in the lumbar spine from the MRI from 2/4/15. Therefore the determination is for not medically necessary.

### **L5-S1 Anterior fusion with interbody fixation:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) ([http://www.odg-twc/odgtwc/low\\_back.htm](http://www.odg-twc/odgtwc/low_back.htm)) ACOEM Low Back Disorders, Revised 2007, pages 209-211.

**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, Fusion.

**Decision rationale:** The ACOEM Guidelines Chapter 12 Low Back Complaints page 307 state that lumbar fusion, "Except for cases of trauma-related spinal fracture or dislocation, fusion of the spine is not usually considered during the first three months of symptoms. Patients with increased spinal instability (not work-related) after surgical decompression at the level of degenerative spondylolisthesis may be candidates for fusion." According to the ODG, Low back, Fusion (spinal) should be considered for 6 months of symptom. Indications for fusion include neural arch defect, segmental instability with movement of more than 4.5 mm, revision surgery where functional gains are anticipated, infection, tumor, deformity and after a third disc herniation. In addition, ODG states, there is a lack of support for fusion for mechanical low back pain for subjects with failure to participate effectively in active rehab pre-op, total disability over 6 months, active psych diagnosis, and narcotic dependence. In this particular patient there is lack of medical necessity for lumbar fusion as there is no evidence of segmental instability greater than 4.5 mm, severe stenosis or psychiatric clearance from the exam note of 9/9/15 to warrant fusion. Therefore the determination is not medically necessary for lumbar fusion.

**Associated surgical service: 1-2 inpatient stay:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**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, Hospital length of stay.

**Decision rationale:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

**Associated surgical service: Vascular assistant surgeon:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM, page 127.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.aaos.org/about/papers/position/1120.asp>.

**Decision rationale:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

**Pre-op History and Physical:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**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, Preoperative testing.

**Decision rationale:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

**Pre-op lab: CBC:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**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, Preoperative testing.

**Decision rationale:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

**Pre-op lab: UA:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**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, Preoperative testing.

**Decision rationale:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

**Pre-op lab: Chem 14:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**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, Preoperative testing.

**Decision rationale:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

**Pre-op EKG:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**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, Preoperative testing.

**Decision rationale:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.