

<b>Case Number:</b>	CM15-0208151		
<b>Date Assigned:</b>	10/28/2015	<b>Date of Injury:</b>	03/26/2014
<b>Decision Date:</b>	12/10/2015	<b>UR Denial Date:</b>	09/23/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/22/2015

### 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 29 year old male, who sustained an industrial injury on March 26, 2014. He reported severe back pain. The injured worker was diagnosed as having lumbar degenerative disc disease. Treatment to date has included diagnostic studies, physical therapy, facet injection with minimal help, epidural with minimal help and medication. On July 22, 2015, MRI of the lumbar spine showed L5-S1 diffuse disc bulge results in moderate to marked bilateral neural foraminal stenosis without impression upon the L5 nerve roots and L4-L5 disc protrusion results in mild neural foraminal narrowing without impression upon the L4 nerve roots. On September 11, 2015, the injured worker complained of back pain that is increased with any type of activity. His lumbar range of motion was noted to be decreased in forward flexion with exacerbation of pain as well as lumbar spine extension with exacerbation of pain. An MRI of the lumbar spine was noted to show severe degenerative disk disease and collapse at L4-L5 and L5-S1. Notes stated that due to the fact the injured worker had failed nonoperative and conservative therapies, the recommendation was for an L4-L5 anterior disk replacement followed by an anterior lumbar fusion at L5-S1. The treatment plan also included vascular surgeon, preop evaluation and clearance, lumbar LSO, Vascutherm and X-rays, 18 post op physical therapy visits. On September 23, 2015, utilization denied a request for L4-L5 anterior disc replacement, L5-S1 anterior discectomy and fusion with instrumentation, post op physical therapy times 18, post op x-ray, lumbar LSO brace purchase, Vascutherm cold therapy purchase, pre-op clearance and vascular surgeon.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **L4-L5 Anterior Disc Replacement; L5-S1 Anterior Discectomy & Fusion with Instrumentation:** Upheld

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

**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 do recommend lumbar surgery if there is clear clinical, electrophysiological and imaging evidence of specific nerve root or spinal cord level of impingement which would correlate with severe, persistent debilitating lower extremity pain unresponsive to conservative management. Documentation does not provide this evidence. His magnetic resonance imaging scan (MRI) showed no severe canal or foraminal stenosis or nerve root impingement. His provider recommended an anterior interbody lumbar discectomy and arthrodesis with instrumentation to treat his lumbago. Documentation does not present evidence of instability or radiculopathy. According to the Guidelines for the performance of fusion procedures for degenerative diseases of the lumbar spine, published by the joint section of the American Association of Neurological surgeons and Congress of Neurological surgeons in 2005 there was no convincing medical evidence to support the routine use of lumbar fusion at the time of primary lumbar disc excision. This recommendation was not changed in the update of 2014. The update did note that fusion might be an option if there is evidence of spinal instability, chronic low back pain and severe degenerative changes. Documentation does not show instability or severe degenerative changes. The California MTUS guidelines do recommend a spinal fusion for traumatic vertebral fracture, dislocation and instability. This patient has not had any of these events. The guidelines note that the efficacy of fusion in the absence of instability has not been proven. The ODG guidelines do not recommend the lumbar disc prosthesis. The requested treatment: L4-L5 Anterior Disc Replacement; L5-S1 Anterior Discectomy & Fusion with Instrumentation is not medically necessary and appropriate.

### **Post Op Physical Therapy x18:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment 2009.

**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 X-ray:** 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.

**Associated Surgical Service: Lumbar LSO Brace Purchase:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Physical Methods.

**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: Vascutherm Cold Therapy (purchase):** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back Lumbar & Thoracic (Acute & Chronic) Chapter (Online Version).

**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 Clearance:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation e-medicine.com.

**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.

**Vascular Surgeon:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American Academy of Orthopedic Surgeons.

**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.