

Case Number:	CM13-0059585		
Date Assigned:	12/30/2013	Date of Injury:	11/09/2011
Decision Date:	04/03/2014	UR Denial Date:	11/08/2013
Priority:	Standard	Application Received:	12/02/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Orthopedic Surgeon, 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 physician 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 patient is a 53 year old male who was injured on 11/09/2011 with low back pain. The mechanism, of injury is unknown. Treatment history included physical therapy, injections, medications, and rest. On 01/22/2013: 1) Cervical 5-6 anterior cervical decompression and fusion. 2) Cervical 5-6 anterior discectomy with placement of PEEK interbody cage. 3) Cervical 5-6 anterior plate instrumentation with Spider titanium plate and four locking screws. Diagnostic studies reviewed include lumbar facet injection dated 11/27/2012. MRI of the lumbar spine dated 09/19/2013 with the impression of: 1. A 5mm broad-based central protrusion at L4-5 leading to mild effacement of the anterior thecal sac. There is outer annular fissuring at midline. 2. A 3 mm broad-based central/left paracentral protrusion at L5-S1 occupying the anterior epidural fat. No displacement of nerve root is seen. On 09/20/2013, thoracic epidural myelogram. Clinic note dated 05/17/2013 documented the patient to remain off work until next appointment. Clinic note dated 09/25/2013 documented the patient to be status post selective nerve root blocks at L4 and L5 on the left side of midline for disc herniations at this levels. The patient is status post thoracic epidural at T8-T9 for thoracic disc extrusion at T8-T9 compressing the cord. The patient improved overall by 25% regarding the thoracic and radicular symptoms on the left side of midline. Objective findings on exam included he has improved range of motion of the lumbosacral spine. He has decreased SLRs. The range of motion of thoracic spine is complete at 0-30 degrees of flexion. Clinic note dated 10/04/2013 documented patient with complaints of low back pain, spasm on left side, radicular symptoms affecting his ability to perform daily activities. States he had minor/temporary relief with injection. Objective findings on exam include L4-L5 HNP, positive straight leg raising on the left, positive EHL weakness on the left, positive spasm and tenderness, paraspinal pain, positive left lower extremity radiculopathy and pain with extension. Clinic note dated 10/31/2013 documented the patient

worse with pain, getting nausea. States insurance denied surgery. Needs pain meds and cannot sleep and has nausea with meds. Objective findings on exam showed positive neural tension and low back pain with range of motion at 30%.

IMR ISSUES, DECISIONS AND RATIONALES

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

L4-5 Total Disc Replacement (TDR): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 219-220. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, regarding Disc Prosthesis

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-306. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back - Lumbar & Thoracic (Acute and Chronic), Disc prosthesis.

Decision rationale: As per CA MTUS guidelines, clear clinical, imaging, and electrophysiologic evidence of a lesion that has been shown to benefit in both the short and long term from surgical repair should be present, specifics for this surgery were not found so the ODG was used. As per ODG, the procedure is not recommended. 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, the patient appears to have chronic lower back pain and objectively, there was positive SLR, positive spasm and tenderness, and weakness. However, there is no evidence of spondylolisthesis or instability at the proposed level and the guidelines do not recommend artificial disc replacement. Thus, the request for total disc replacement at L4-5 is not medically necessary and is non-certified.

L5-S1 Anterior Lumbar Interbody Fusion (ALIF) Hybrid Procedure: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 219-220.

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 - Lumbar & Thoracic (Acute & Chronic), Fusion (spinal).

Decision rationale: As per CA MTUS guidelines, there is no good evidence from controlled trials that spinal fusion alone is effective for treatment any type of acute low back problem, in the absence of spinal fracture, dislocation, or spondylolisthesis if there is instability and motion in the segment operated on. As per ODG, spinal fusion is not recommended for patients who have less than six months of failed recommended conservative care unless there is objectively demonstrated severe structural instability and/or acute or progressive neurologic dysfunction, but

recommended as an option for spinal fracture, dislocation, spondylolisthesis or frank neurogenic compromise. In this case, the patient appears to have chronic lower back pain and objectively, there was positive SLR, positive spasm and tenderness, and weakness. However, there is no MRI evidence of spondylolisthesis or instability at the proposed level and hence the request for ALIF at L5-S1 is non-certified.

L4-S1 Discograms with [REDACTED]: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 66-67.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-310. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back - Lumbar & Thoracic (Acute and Chronic), Discography.

Decision rationale: As per CA MTUS guidelines, discography may be used where fusion is a realistic consideration, and it may provide supplemental information prior to surgery. As per CA MTUS guidelines and ODG, the criteria for discography is "back pain of at least three months duration, failure of conservative treatment, satisfactory results from detailed psychosocial assessment (discography in subjects with emotional and chronic pain problems has been linked to reports of significant back pain for prolonged periods after injection, and therefore should be avoided), is a candidate for surgery, and has been briefed on potential risks and benefits from discography and surgery." In this case, this patient has chronic lower back pain radiating to left lower extremity with positive tenderness, spasm, restricted ROM, and weakness despite treated with conservative care. However, there is no documentation of psychosocial evaluation performed prior to undergoing this intervention. Also, without the approval for lumbar surgery, the request for discogram is not medically necessary and is non-certified.

Pre-op medical clearance with PCP: 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 - Lumbar & Thoracic (Acute and Chronic), Preoperative Echocardiogram, Preoperative lab testing, Preoperative testing, general and American Society of Anesthesiologists Task Force on Preanesthesia Evaluation: 2002, Fe

Decision rationale: As per the above referenced guidelines, the pre-op medical clearance is medically necessary. However, since the surgical procedures are not medically necessary, none of the associated requests are medically necessary and appropriate and thus the request is non-certified.

3-day inpatient stay:

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 - Lumbar & Thoracic (Acute & Chronic), Hospital Length of Stay (LOS).

Decision rationale: CA MTUS guidelines do not discuss the issue in dispute and hence ODG have been consulted. As per ODG, 3-day inpatient stay is recommended. However, since the proposed surgical procedures are not medically necessary, none of the associated requests are medically necessary and appropriate and thus the request is non-certified.

Assistant surgeon: 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 Milliman Care Guidelines (MCG), Inpatient and Surgical Care 17th Edition, Assistant Surgeon Guidelines.

Decision rationale: As per the referenced guidelines, assistant surgeon is recommended; however, since the surgical procedures are not medically necessary, none of the associated requests are medically necessary and appropriate and thus the request is non-certified.

Postoperative physical therapy 2 times 8 for the lumbar: Upheld

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

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 26.

Decision rationale: As per CA MTUS postsurgical treatment guidelines, 34 visits of postop physical therapy is recommended; however, since the surgical procedures are not medically necessary, none of the associated requests are medically necessary and appropriate and thus the request is non-certified.

Lumbar aspen LSO brace: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back - Lumbar & Thoracic (Acute & Chronic), Back brace, postoperative (fusion).

Decision rationale: As per CA MTUS guidelines, lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. As per ODG, not recommended for prevention..... There is no scientific information on the benefit of bracing for improving fusion rates or clinical outcomes following instrumented lumbar fusion for degenerative disease." The above noted guidelines do not support its use postoperatively and since the surgical procedures are not medically necessary, none of the associated requests are medically necessary and appropriate and thus the request is non-certified.