

Case Number:	CM15-0033968		
Date Assigned:	02/27/2015	Date of Injury:	11/22/2014
Decision Date:	05/13/2015	UR Denial Date:	01/28/2015
Priority:	Standard	Application Received:	02/23/2015

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 35-year-old male who reported injury on 11/22/2014. The mechanism of injury was the injured worker was performing a controlled takedown of a female suspect and he grabbed the suspect's left arm with his right hand and turned to the left using his momentum to take the suspect to the ground; while doing this the injured worker felt a pop in his low back. The injured worker complained of sharp low back pain with sometimes a soreness and dull aching and electrical pain. The injured worker had associated tightness, stiffness, numbness, tingling, popping and weakness. The physical examination revealed discogenic scoliosis to the right and spinal mobility due to paraspinal muscle spasm was severely limited. The sciatic stretch signs were markedly positive on the right, both in the seated and supination positions, at 50 degrees to 60 degrees. There was decreased sensation in the L4-5 distribution. There was weakness of the L4-5 innervated musculature. The injured worker had an antalgic gait. The injured worker was noted to bring in a previous MRI of the lumbar spine, which revealed L4-5 herniated nucleus pulposus. The diagnoses included L4-5 degenerative disc disease with right lower extremity radiculopathy. A request was made for physical therapy for the lumbar spine and for surgical intervention including an L4-5 total disc replacement versus total lumbar interbody fusion. Additionally, the request was made for preoperative durable medical equipment and physical therapy. The documentation indicated the injured worker underwent EMG and nerve conduction studies on 12/10/2014, which revealed findings consistent with right S1 radiculopathy. There was a Request for Authorization submitted for review dated 01/21/2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

L4-5 Total disc versus transforaminal lumbar interbody fusion with 3 days in patient stay and assistant surgeon: 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): 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back Chapter, Disc prosthesis.

Decision rationale: The American College of Occupational and Environmental Medicine indicate a surgical consultation may be appropriate for injured workers who have severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies preferably with accompanying objective signs of neural compromise. There should be documentation of activity limitations due to radiating leg pain for more than 1 month or the extreme progression of lower leg symptoms, and 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 and documentation of a failure of conservative treatment to resolve disabling radicular symptoms. Additionally, there is no good evidence from controlled trials that spinal fusion alone is effective for treating 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. The American College of Occupational and Environmental Medicine guidelines do not address artificial disc replacement. As such, secondary guidelines were sought. The Official Disability Guidelines indicate that disc prosthesis is not recommended. The clinical documentation submitted for review indicated the injured worker had objective findings upon evaluation. However, there was a lack of documentation of a failure of conservative care. The imaging and electrophysiologic evidence were not provided for review. As the request for the total disc replacement or transforaminal lumbar interbody fusion are not medically necessary, the request for the 3 day inpatient stay and assistant surgeon would not be medically necessary. There was a lack of documentation of flexion and extension studies to support the injured worker had instability upon examination. Given the above, the request for L4-5 total disc versus transforaminal lumbar interbody fusion with 3 days in patient stay and assistant surgeon is not medically necessary.

Post-Operative Physical Therapy, Twice a Week for Six Weeks: Upheld

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

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-Operative Medical Clearance: Upheld

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

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.