

<b>Case Number:</b>	CM15-0062317		
<b>Date Assigned:</b>	04/08/2015	<b>Date of Injury:</b>	05/19/2011
<b>Decision Date:</b>	05/11/2015	<b>UR Denial Date:</b>	03/26/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/01/2015

### 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

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:

This 39 year old woman sustained an industrial injury on 5/19/2011. The mechanism of injury is not detailed. Evaluations include electromyogram/nerve conduction studies dated 2/2/2015, lumbar spine MRI from 2014, and a discogram and lumbar spine CT scan dated 3/2/2015. Diagnoses include discogenic pain and degenerative disc disease with annular tears. Treatment has included oral medications, epidural steroid injections, and surgical intervention with post-operative physical therapy. Physician notes dated 3/13/2015 show complaints of low back pain. Recommendations include surgical intervention.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Anterior Lumbar Discectomy with Total Disc Replacement with Possible Fusion: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-328.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307.

**Decision rationale:** 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 California MTUS guidelines note that surgical consultation is indicated if the patient has persistent, severe and disabling lower extremity symptoms. The documentation shows this patient has been complaining of pain in the back. Documentation does not disclose disabling lower extremity symptoms. The guidelines also list the criteria for clear clinical, imaging and electrophysiological evidence consistently indicating a lesion which has been shown to benefit both in the short and long term from surgical repair. Documentation does not show this evidence. The requested treatment is for an anterior lumbar discectomy and possible fusion. The guidelines note that the efficacy of fusion without instability has not been demonstrated. Documentation does not show instability. The requested treatment: Anterior Lumbar Discectomy with Total Disc Replacement with Possible Fusion is not medically necessary and appropriate.

**Preoperative Clearance Testing / Preoperative Lab Work:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation URL (<http://www.guideline.gov/content.aspx?id=48408>); Official Disability Guidelines: Low Back - Preoperative Testing.

**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.

**Aspen Summit Brace, 2 To 4 Weeks Preoperative:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-328.

**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.

**Cold Therapy Unit, 2 To 4 Weeks Preoperative:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-328. Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back - Cold/Heat packs.

**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.