

<b>Case Number:</b>	CM15-0079551		
<b>Date Assigned:</b>	04/30/2015	<b>Date of Injury:</b>	08/17/2012
<b>Decision Date:</b>	06/01/2015	<b>UR Denial Date:</b>	04/23/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/25/2015

### 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:

The injured worker is a 20 year old male/female, who sustained an industrial/work injury on 8/17/12. She reported initial complaints of back pain. The injured worker was diagnosed as having lumbar disc disease with central disc herniation at L5-S1. Treatment to date has included medication, diagnostics, surgery (L4-5 discectomy on 7/2014), epidural steroid injections, physical therapy, and transcutaneous electrical nerve stimulation (TENS) unit. Currently, the injured worker complains of low back pain. Per the primary physician's progress report (PR-2) on 4/15/15, exam reveals right knee satisfactory sensory, motor, and reflexes. Lachman sign is negative. Recent MRI of the lumbar spine revealed substantial degeneration of the L4-5 disc, with central herniation. The requested treatments include Lumbar 4-5, 5-S1 Disc Replacement with Discectomy and Arthroplasty, Associated Surgical Service: 3 Inpatient Stay, and Pre-Op Appointment with Treating Physician.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Lumbar 4-5, 5-S1 Disc Replacement with Discectomy and Arthroplasty:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): s 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter-Disc prosthesis.

**Decision rationale:** The California MTUS guidelines recommend surgery when the patient has had severe persistent, debilitating lower extremity complaints referable to a specific nerve root or spinal cord level corroborated by clear imaging, clinical examination and electrophysiological studies. Documentation does not provide this evidence. The guidelines note the patient would have failed a trial of conservative therapy. The guidelines note the surgical repair proposed for the lesion must have evidence of efficacy both in the short and long term. Documentation does not provide this evidence. ODG guidelines do not recommend lumbar disc prosthesis. The requested treatment: Lumbar 4-5, 5-S1 Disc Replacement with Discectomy and Arthroplasty is NOT Medically necessary and appropriate.

**Associated Surgical Service: 3 day 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 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 Appt with Treating Physician:** 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.