

<b>Case Number:</b>	CM15-0092470		
<b>Date Assigned:</b>	05/18/2015	<b>Date of Injury:</b>	05/16/2008
<b>Decision Date:</b>	06/23/2015	<b>UR Denial Date:</b>	04/30/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/13/2015

### 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: Illinois, California, 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 53-year-old who sustained an industrial injury on 5/16/08. The mechanism of injury was not documented. Records documented chronic low back pain and positive neurologic findings with requests noted for anterior posterior spinal fusion at L5/S1, and anterior lumbar interbody fusion at L4/5 and L5/S1. Previous requests for lumbar surgery were authorized in 2011 and 2014, but surgery had not occurred according to the records. The 3/26/15 lumbar spine MRI impression documented multilevel degenerative disc bulges, most significant at the L4/5 level where there may be impingement of the bilateral transiting nerve roots. Findings documented a broad-based disc bulges at L2/3 and L3/4 causing mild central canal stenosis with no significant neuroforaminal stenosis. At L4/5, there was a broad-based disc bulge causing mild to moderate central canal stenosis with possible impingement of the bilateral transiting nerve root with no significant neuroforaminal stenosis. At L5/S1, there was a broad-based disc bulge causing no significant central canal stenosis or neuroforaminal stenosis. Records documented that a 3/27/15 lumbar spine CT scan revealed severe disc degeneration at L5/S1 with adjacent vertebral end-plate sclerosis. There was a 3 mm posterolateral disc osteophyte complex at L5/S1 that contributed to moderate right and mild left L5/S1 foraminal encroachment not significantly changed compared to prior examination. There was a stable 2-3 mm broad-based posterior disc bulge at L4/5 that resulted in mild canal stenosis. There was interval development of a 3.4 to 4 mm far left posterolateral disc protrusion at L4/5 resulting in mild to moderate left foraminal encroachment. Records documented a 4/8/15 spine surgery report with review of the MRI and CT scan results. Relative to the lumbar spine, the CT scan

indicated that the L5/S1 facets were relatively spared. Relative to the cervical spine, there was significant spondylotic collapse at C5/6 with significant foraminal stenosis. The injured worker had significant neck pain with bilateral upper extremity radiculopathy, and wrist flexion/extension weakness. She wanted definitive management of the cervical spine. She had failed anti-inflammatories, physical therapy, and epidurals. The treatment plan recommended artificial disc replacement at C5/6 and L5/S1. The 4/23/15 request for authorization requested authorization for artificial disc replacement C5/6 versus anterior cervical discectomy and fusion C5/6, followed 6 weeks later by artificial disc replacement at L5/S1, and medical clearance of diagnoses of cervical stenosis and lumbar spondylosis. The 4/30/15 utilization review non-certified the request for lumbar artificial disc replacement as recent studies had failed to demonstrate superiority of disc replacement.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Artificial disc replacement at L5-S1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 306. Decision based on Non-MTUS Citation Official Disability Guidelines Low Back, Lumbar and Thoracic Chapter - Disc Prosthesis.

**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, Disc prosthesis.

**Decision rationale:** CA MTUS/ACOEM is silent on the issue of disc arthroplasty. According to the ODG, Low Back, Disc prosthesis, it is not recommended. It states, "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." As the guidelines do not recommend lumbar disc arthroplasty, the determination is for non-certification.