

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Notice of Independent Medical Review Determination

Dated: 11/25/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	6/12/2013
Date of Injury:	3/2/2013
IMR Application Received:	8/5/2013
MAXIMUS Case Number:	CM13-0007342

- 1) MAXIMUS Federal Services, Inc. has determined the request for **minimally invasive lumbar L3-S1 percutaneous needle discectomy is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **post-procedure PT 3x2 is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/5/2013 disputing the Utilization Review Denial dated 6/12/2013. A Notice of Assignment and Request for Information was provided to the above parties on 9/4/2013. A decision has been made for each of the treatment and/or services that were in dispute:

- 1) MAXIMUS Federal Services, Inc. has determined the request for **minimally invasive lumbar L3-S1 percutaneous needle discectomy is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **post-procedure PT 3x2 is not medically necessary and appropriate.**

Medical Qualifications of the Expert Reviewer:

The independent Medical Doctor who made the decision has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Orthopedic Surgery, 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 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 treatments and/or services at issue.

Expert Reviewer Case Summary:

This patient is a 58-year-old male who reported an injury on 03/02/2013. Notes indicate that the patient was initially injured as the result of a fall from a height of 4 and a half feet off of a platform, with the patient landing on his low back, left wrist, and hand. The patient was evaluated on 03/05/2013 with radiographs of the right wrist noting a non-displaced hairline fracture and x-rays of the lumbar spine noting narrowed disc space at L5-S1. The patient's history includes an MRI of the lumbar spine which was obtained on 11/08/2012 which revealed a 3 mm broad based disc bulge at L3-4 and L4-5, with mild right and moderate left neural foraminal narrowing at L3-4 and moderate right and mild left foraminal narrowing at L4-5. At the L5-S1 level, the disc space was noted to be narrowed with a 3 mm broad based disc bulge identified and associated with annular tearing and mild bilateral neural foraminal narrowing. Notes indicate that the patient has been tried on various nonoperative treatment modalities and that the patient has undergone a long course of anti-inflammatory medications, analgesics, and other medication treatments. Furthermore, notes indicate that the patient has had a prolonged course of various therapies, all of which provided only temporary relief to the patient and with the patient's low back pain and radiculitis being persistent.

Documents Reviewed for Determination:

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- Application of Independent Medical Review
- Utilization Review Determination
- Medical Records from Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

1) Regarding the request for minimally invasive lumbar L3-S1 percutaneous needle discectomy:**Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision**

The Claims Administrator based its decision on Low Back Complaints (American College of Occupational and Environmental Medicine (ACOEM) Practice Guidelines, 2nd Edition (2004), Chapter 12) pg. 306, which is a part of the MTUS, and on the Official Disability Guidelines (ODG), Low Back Procedure Summary, no specific page number(s) cited.

The Expert Reviewer based his/her decision on Low Back Complaints (American College of Occupational and Environmental Medicine (ACOEM) Practice Guidelines, 2nd Edition (2004), Chapter 12) pg. 305-307, which is a part of the MTUS.

Rationale for the Decision:

MTUS/ACOEM Guidelines indicate that within the first three months of acute onset of low back symptoms, surgery is considered only when serious spinal pathology or nerve root dysfunction not responsive to conservative therapy is detected. Lumbosacral nerve root decompression inclusive of laminotomy, standard discectomy, and laminectomy are direct methods of nerve root decompression. Surgical discectomy for carefully selected patients with nerve root compression due to lumbar disc prolapse provides faster relief from an acute attack than conservative treatment, but any positive or negative effects on the lifetime natural history of the underlying disc disease are still unclear. Furthermore, the Guidelines indicate the recommendation for surgical consideration for employees with severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies, preferable with accompanying objective signs of neural compromise as well as activity limitation due to radiating leg pain for more than one month or extreme progression of lower leg symptoms and for employees with clear clinical, imaging, and electrophysiologic evidence of a lesion that had been shown to benefit in both the short and long-term from surgical repair as well as failure of conservative treatment to resolve radicular symptoms.

The medical records provided for review indicate on physical examination of the thoracic and lumbar spine as of 05/08/2013 that there was hypolordosis noted. There were spasms of the lumbar spine as well as tenderness over the lumbar paravertebral area on the left. The abdominal and back musculature showed 4/5 strength with flexion, extension, and left lateral flexion, and that upon toe walk and heel walk, there was no complaint of any radicular symptomatology or weakness. The employee had good dorsiflexion and plantar flexion strength and negative straight leg raise. Trigger points were noted in the erector spinals area on the left and foraminal compression test were positive of the lumbar spine on the left. There was general muscle weakness noted secondary to pain on the left and range of motion was restricted secondary to pain. Lumbar flexion was rated at 45 degrees, extension at 5 degrees, right and left lateral bending of 25 degrees and 10 degrees respectively with bilateral rotation of 30 degrees. The most recent evaluation of the employee on 06/06/2013 noted only upon re-evaluation, the employee had complaints of lumbar spine pain which was constant. Moreover, evaluation of the employee was insufficient to detail radicular symptoms on comprehensive evaluation of 05/08/2013. Furthermore, official imaging studies for the lumbar spine and electrodiagnostic tests were not submitted for review and while notes indicate that the employee has undergone various conservative treatments and a prolonged course of various therapies, there is a lack of documentation indicating the employee's overall functional response or to clearly delineate what these types of therapies were prior to the request for surgery. While the employee was noted to have general muscle weakness and pain to the left lower extremity, the employee was able to walk on heels and toes with no complaint of any radicular symptomatology, straight leg raise was noted to be negative, and the employee had evidence of good dorsiflexion and plantar flexion strength. **The request for minimally invasive lumbar L3-S1 percutaneous needle discectomy is not medically necessary and appropriate.**

2) **Regarding the request for post-procedure PT 3x2:**

Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Effect of the Decision:

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the final determination of the Administrative Director, Division of Workers' Compensation. With respect to the medical necessity of the treatment in dispute, this determination is binding on all parties.

In accordance with California Labor Code Section 4610.6(h), a determination of the administrative director may be reviewed only if a verified appeal is filed with the appeals board for hearing and served on all interested parties within 30 days of the date of mailing of the determination to the employee or the employer. The determination of the administrative director shall be presumed to be correct and shall be set aside only upon proof by clear and convincing evidence of one or more of the grounds for appeal listed in Labor Code Section 4610.6(h)(1) through (5).

Sincerely,

Paul Manchester, MD, MPH
Medical Director

cc: Department of Industrial Relations
Division of Workers' Compensation
1515 Clay Street, 18th Floor
Oakland, CA 94612

/ejf

Disclaimer: MAXIMUS is providing an independent review service under contract with the California Department of Industrial Relations. MAXIMUS is not engaged in the practice of law or medicine. Decisions about the use or nonuse of health care services and treatments are the sole responsibility of the patient and the patient's physician. MAXIMUS is not liable for any consequences arising from these decisions.