

Case Number:	CM13-0059966		
Date Assigned:	12/30/2013	Date of Injury:	12/10/2012
Decision Date:	06/27/2014	UR Denial Date:	10/31/2013
Priority:	Standard	Application Received:	12/02/2013

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. The expert 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 disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient is a 42 year old male with a 12/10/12 date of injury. The patient was seen on 10/16/13 with complaints of low back pain at the base with associated cramping. He also complains of leg cramping. A recent lumbar epidural steroid injection improved the low back pain and leg cramping somewhat but the pain has returned. An exam revealed the patient is focally tender at L4/5 and L5/S1 as well as the superior iliac crest. There is limited L spine range of motion; strength is noted to be intact. An electrodiagnostic study done on 6/27/13 revealed normal NCS and EMG of the legs bilaterally. The patient has a diagnosis of Disc bulge at L3/4, L4/5, discogenic disease at L5/S1, severe foraminal stenosis bilaterally at L5-S1, and moderate stenosis at L3/4 and mild to moderate stenosis at L4/5. A UR decision dated 10/31/13 denied the request given no type of decompression and instrumentation being requested, in addition, per-op labs were not specified nor was a provider for the pre op medical clearance. The associated surgical requests for pre op labs and EKG, cold therapy unit with DVT and lumbar wrap, and 1-2 day inpatient stay were also not certified as surgery was not certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

DECOMPRESSION AT L3-4, L4-5, AND L5-S1 LEVELS WITH POSSIBLE INSTRUMENTATION AT L3-4 AND L4-5: 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 rationale: California MTUS states that surgical intervention is recommended for patients who have severe and disabling lower leg symptoms in the distribution consistent with abnormalities on imaging studies (radiculopathy), preferably with accompanying objective signs of neural compromise; activity limitations due to radiating leg pain for more than one month or extreme progression of lower leg symptoms; 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 failure of conservative treatment. In addition, California MTUS states that 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. This is a 42-year-old male with bilateral leg cramping and low back pain with no notable strength deficits in the legs bilaterally. However, disabling lower leg symptoms were not described in the documentation provided. Recent electrodiagnostic studies of the lower extremities were negative. In addition, an MRI was not provided for review. Dynamic instability or degenerative spondylolisthesis was not corroborated by imaging report. Psychological clearance was not obtained. Given the lack of documentation of imaging, a negative electrodiagnostic study, and an inadequate description of the disabling lower leg symptoms, this request was not medically necessary.

PRE OP MEDICAL CLEARANCE TO INCLUDE CONSULTATION, LABS, CHEST X-RAYS, AND EKG: 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.

COLD THERAPY UNIT WITH DVT AND LUMBAR WRAP: 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.

1-2 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.