MAXIMUS Federal Services

Case Number:	CM13-0063825		
Date Assigned:	12/30/2013	Date of Injury:	10/08/2008
Decision Date:	04/25/2014	UR Denial Date:	12/02/2013
Priority:	Standard	Application Received:	12/10/2013

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:

This 64-year-old claimant has a date of injury of 10/8/08. She has been treated for back and leg pain. This claimant was seen by [redacted] of Neurosurgery in September 2013. His note document continued complaints of low back pain and numbness in the lower extremities. Examination demonstrated sensation was intact to light touch and pinprick in all dermatomes of the bilateral lower extremities and lower extremity strength was 5/5. An MRI was performed on 8/19/13 of the claimant's lumbar spine which demonstrated spondylitic changes throughout. At the L3-4 level, there was a suggestion of a 6 mm right lateral soft herniated disc causing moderate right foraminal stenosis and at the L5-S1 level severe degenerative disc disease with no significant central spinal lateral recess or foraminal stenosis present. L5-S1 micro-discectomy, L3-4 right-sided micro-discectomy, lab work, chest x-ray, bone growth stimulator, walker, neuro vision stimulator, home health evaluation, and post-operative appointment were requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

Post-Op Appointment with [redacted], QTY:1.00: 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.

Home Health Evaluation QTY: 1.00: 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.

Neuro Vision Stimulator QTY 1.00: 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.

Walker QTY: 1.00: 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.

Bone Growth Stimulator QTY:1.00: 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.

Chest X-Ray (CXR) QTY:1.00: 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.

Full Lab Work QTY: 1.00: 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.

Right Lumbar Laminectomy and Discectomy at L3-L4 QTY: 1.00: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

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

Decision rationale: Nerve root decompression is appropriate if there are findings of radiculopathy on physical examination which correlate to a neurocompressive lesion noted on MRI and after the claimant has failed appropriate conservative care. In this particular case, there is no evidence of radiculopathy based on the physical examination. The MRI does not demonstrate any convincing neurocompressive lesions. Therefore, the requested surgery cannot be certified in this case.

Minimally Invasive Lumbar Microdiscectomy at L5-S1, QTY 1.00: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

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

Decision rationale: Micro-discectomy is appropriate if there are findings of radiculopathy on physical examination which correlate to a neurocompressive lesion noted on MRI and after the claimant has failed appropriate conservative care. In this particular case, there is no evidence of radiculopathy based on the physical examination. The MRI does not demonstrate any

convincing neurocompressive lesions. Therefore, micro-discectomy at L5-S1 and L3-4 cannot be certified in this case.