

Case Number:	CM14-0007791		
Date Assigned:	06/11/2014	Date of Injury:	09/19/2011
Decision Date:	07/24/2014	UR Denial Date:	12/17/2013
Priority:	Standard	Application Received:	01/21/2014

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 injured worker is a 38-year-old female who reported an injury on 09/19/2011. The mechanism of injury was not stated. The current diagnosis is lumbar disc herniation at L5-S1 with bilateral neural foraminal stenosis. The injured worker was evaluated on 11/26/2013 with complaints of neck and lower back pain. Physical examination of the lumbar spine revealed normal lordosis, paraspinal spasm, tenderness to palpation, positive sciatic notch tenderness, limited range of motion, positive straight leg raising bilaterally, decreased sensation over the left lower extremity and 4/5 strength in the bilateral lower extremities. Treatment recommendations at that time included an L5-S1 bilateral laminotomy, microdiscectomy, and foraminotomy.

IMR ISSUES, DECISIONS AND RATIONALES

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

L5-S1 BILATERAL LAMINOTOMIES: 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 (ODG) Low Back Chapter, Discectomy/ laminectomy.

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 Chapter, Laminectomy/Laminotomy.

Decision rationale: California MTUS/ACOEM Practice Guidelines state a surgical consultation may be indicated for patients who have severe and disabling lower extremity symptoms, activity limitations for more than 1 month, clear clinical, imaging and electrophysiologic evidence of a lesion and a failure of conservative treatment. Official Disability Guidelines state a laminotomy is recommended for lumbar spinal stenosis. For patients with lumbar spinal stenosis, surgery offered a significant advantage over nonsurgical treatment in terms of pain relief and functional improvement. As per the documentation submitted, there was no imaging studies provided for this review. There is no mention of an exhaustion of conservative treatment prior to the request for a surgical procedure. Based on the clinical information received, the injured worker does not meet criteria for the requested procedure. As such, the request for L5-S1 Bilateral Laminotomies is not medically necessary and appropriate.

L5-S1 BILATERAL MICRODISCECTOMY: 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 (ODG) Low Back Chapter, Discectomy/ laminectomy.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-306. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Discectomy/ laminectomy.

Decision rationale: California MTUS/ACOEM Practice Guidelines state a surgical consultation may be indicated for patients who have severe and disabling lower extremity symptoms, activity limitation for more than 1 month, clear clinical, imaging and electrophysiologic evidence of a lesion, and a failure of conservative treatment. Official Disability Guidelines state prior to a discectomy/laminectomy, there should be objective evidence of radiculopathy upon physical examination. Imaging studies should reveal nerve root compression, lateral disc rupture, or lateral recess stenosis. Conservative treatment should include activity modification, drug therapy, and epidural steroid injections. There should also be evidence of a referral to physical therapy, manual therapy, or the completion of a psychosocial screening. The injured worker does not meet any of the above mentioned criteria for a Discectomy/Laminectomy/Foraminotomy. There is no evidence of an exhaustion of conservative treatment. There was no imaging studies provided for this review. Based on the clinical information received and the above mentioned guidelines, the request for L5-S1 bilateral Microdiscectomy is not medically necessary and appropriate.

L5-S1 BILATERAL FORMINOTOMY: 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 (ODG) Low Back Chapter, Discectomy/ laminectomy.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-306. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Discectomy/ laminectomy.

Decision rationale: California MTUS/ACOEM Practice Guidelines state a surgical consultation may be indicated for patients who have severe and disabling lower extremity symptoms, activity limitation for more than 1 month, clear clinical, imaging and electrophysiologic evidence of a lesion, and a failure of conservative treatment. Official Disability Guidelines state prior to a discectomy/laminectomy, there should be objective evidence of radiculopathy upon physical examination. Imaging studies should reveal nerve root compression, lateral disc rupture, or lateral recess stenosis. Conservative treatment should include activity modification, drug therapy, and epidural steroid injections. There should also be evidence of a referral to physical therapy, manual therapy, or the completion of a psychosocial screening. The injured worker does not meet any of the above mentioned criteria for a discectomy/laminectomy/foraminotomy. There is no evidence of an exhaustion of conservative treatment. There was no imaging studies provided for this review. Based on the clinical information received and the above mentioned guidelines, the request for L5-S1 Bilateral Foraminotomy is not medically necessary and appropriate.

1 ASSISTANT SURGEON: 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 DAYS INPATIENT HOSPITALIZATION: 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 HOME HEALTH EVALUATION WITH [REDACTED]: 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.

UNKNOWN TRANSPORTATION SERVICES: 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 OFF THE SHELF LUMBAR BRACE: 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 FRONT WHEELED WALKER: 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 INTERNAL MEDICINE CLEARANCE: 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.