MAXIMUS Federal Services

Case Number:	CM14-0114670		
Date Assigned:	08/04/2014	Date of Injury:	05/05/2003
Decision Date:	09/10/2014	UR Denial Date:	06/24/2014
Priority:	Standard	Application Received:	07/21/2014

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:

This 62-year-old male sustained an industrial injury on 5/5/03. The mechanism of injury was not documented. A left L4/5 and L5/S1 transforaminal epidural steroid injection was performed on 4/3/14. The 4/17/14 treating physician report indicated the patient did not get any lasting relief with the last injection. A new MRI was recommended because of severe, consistent leg pain and progressive weakness. The 5/16/14 lumbar spine MRI impression documented interval mild progression in grade 1 anterolisthesis of L3 on L4 and L4 on L5 with development of a broad-based 4 mm central/left paracentral disc protrusion at L4/5 resulting in mild spinal canal stenosis, effacement of the left subarticular recess, and likely impinging on the descending left L5 nerve roots. There was mild right L3/4 and L4/5 neuroforaminal narrowing. The 6/20/14 treating physician report cited bilateral leg pain, left greater than right. He could only walk 3 blocks. He was not symptomatically worse. Physical exam documented mild left dorsiflexion weakness, numbness over the lateral calf, positive straight leg raise, limited lumbar flexibility, and 1+ reflexes. He walked with a forward tilted lumbar spine. MRI findings were discussed. Lumbar laminectomy L3-S1 was recommended. The 6/24/14 utilization review denied the request for L3-S1 lumbar laminectomy as there was no detailed documentation of conservative treatment, no electrodiagnostic evidence of radiculopathy, and no evidence of nerve root impingement to support all surgical levels.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar Laminectomy L3-S-1: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 26.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 202-208. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic, Discectomy/Laminectomy.

Decision rationale: The ACOEM Revised Low Back Disorder guidelines recommend decompression surgery as an effective treatment for patients with symptomatic spinal stenosis (neurogenic claudication) that is intractable to conservative management. The Official Disability Guidelines recommend criteria for decompression surgery (lumbar discectomy and laminectomy) that includes symptoms/findings that confirm the presence of radiculopathy and correlate with clinical exam and imaging findings. Guideline criteria include evidence of nerve root compression, imaging findings of nerve root compression, lateral disc rupture, or lateral recess stenosis, and completion of comprehensive conservative treatment. Guidelines require all of the following conservative treatments: activity modification for at least 2 months, drug therapy, and referral for physical medicine (physical therapy, manual therapy). Guideline criteria have not been met. There is imaging documentation of nerve root compression of the left L5 nerve roots that is consistent with exam findings. Spinal stenosis is documented as mild at L4/5. There are no clinical or imaging findings indicative of spinal stenosis or nerve root compression at the other requested surgical levels. There is no electrodiagnostic evidence of radiculopathy documented. There is no detailed documentation that recent comprehensive guidelines-recommended conservative treatment had been tried and failed. Therefore, this request for lumbar laminectomy L3-S1 is not medically necessary.

Post-operative physical therapy 3 times weekly for 4 weeks for the lumbar: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 26.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 26.

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

Inpatient hospitalization stay 2 days: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, LOS guidelines.

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 - Lumbar & Thoracic, Hospital length of stay (LOS).

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

Surgical assistant: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American Association of Orthopaedic Surgeons position, first assistant at surgery.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Centers for Medicare and Medicaid services, Physician Fee Schedule.

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