

Case Number:	CM14-0040316		
Date Assigned:	06/27/2014	Date of Injury:	10/03/2012
Decision Date:	07/23/2014	UR Denial Date:	03/17/2014
Priority:	Standard	Application Received:	04/07/2014

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 Orthopaedic 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 39-year-old male sustained an industrial injury on 5/12/12, when he slipped in some oil and twisted. Past medical history was positive for left L5/S1 microdiscectomy on 3/21/05. The 1/20/14 treating physician report cited low back tightness and pain radiating to his left knee. Left leg weakness and numbness/tingling in the left foot was documented. Chiropractic treatment was not successful. Physical exam findings documented marked loss of lumbar extension and moderate loss of all other motions. Sensation was decreased over the left leg. Left tibialis anterior, extensor hallucis longus, inversion, eversion and plantar flexion were 4+/5. All other upper and lower extremity strength is 5/5. Deep tendon reflexes were normal. There was a positive left straight leg raise, positive left slump test, and positive cross straight leg raise test. The 3/24/14 utilization review denied the request for lumbar surgery and associated chiropractic/physiotherapy treatment as the medical necessity was not established with clear clinical and electrophysiologic evidence consistent with the requested surgical level. The 2/28/14 appeal letter stated that the diagnostic impressions were consistent with the patient's present and persisting signs and symptoms, and positive orthopedic evaluation findings. These findings were indicative of further surgical intervention. The patient had progressively worsened despite on-going conservative treatment and activity modification. The 8/28/12 lumbar MRI (magnetic resonance imaging) reportedly showed left subarticular disc protrusion with moderate central canal and left neuroforaminal stenosis at L4/5. The 8/28/12 lower extremity electromyography (EMG)/NCV (nerve conduction velocity) showed evidence of probable L5 and S1 radiculopathy. An updated MRI was requested. The provider again requested left L4/5 micro-lumbar decompression.

IMR ISSUES, DECISIONS AND RATIONALES

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

MICRO-LUMBAR DECOMPRESSION L4-L5: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

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, Microdiscectomy, Discectomy/Laminectomy.

Decision rationale: The Official Disability Guidelines (ODG) recommends lumbar discectomy for patients with radiculopathy due to on-going nerve root compression who continue to have significant pain and functional limitation after 4 to 6 weeks of time and appropriate conservative therapy. The indications include radicular pain syndrome with current dermatomal pain and/or numbness, or myotomal muscle weakness all consistent with a herniated disc. Imaging findings are required that confirm persisting nerve root compression at the level and on the side predicted by the history and clinical examination. There must be continued significant pain and functional limitation after four to six weeks of time and appropriate conservative therapy. The ODG criteria have not been met. In this case, there is no current documentation of dermatomal pain and/or numbness, and myotomal weakness to support the medical necessity of surgery at L4/5. There is no clear imaging documentation evidencing nerve root compression at L4/5. An updated MRI (magnetic resonance imaging) was requested by the treating physician. There is no detailed documentation that recent comprehensive pharmacologic and non-pharmacologic conservative treatment had been tried and failed. Therefore, the request for micro-lumbar decompression at left L4-L5 is not medically necessary.

POST-OP CHIROPHYSIOTHERAPY TIMES TWELVE (X12): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: Since the primary procedure (micro-lumbar decompression at L4-L5) is not medically necessary, none of the associated services (post-operative chiro-physiotherapy times twelve (x12)) are medically necessary.