MAXIMUS Federal Services

Case Number:	CM14-0059573		
Date Assigned:	07/09/2014	Date of Injury:	10/13/2005
Decision Date:	08/08/2014	UR Denial Date:	04/28/2014
Priority:	Standard	Application Received:	04/30/2014

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 52-year-old female sustained an industrial injury on 10/13/05. The 7/16/12 bilateral lower extremity EMG/NCS was normal. The 8/14/12 lumbar MRI impression documented degenerative disc disease, most pronounced at L4-S1 with disc dehydration, disc height loss and anterior spondylosis. There was mild right neuroforaminal narrowing at L3-4. At L4-5, there was a disc protrusion and annular fissure with mild to moderate canal stenosis and narrowing of the left lateral recess. An L5-S1 central protrusion/extrusion resulted in moderate canal stenosis and contact of the bilateral S1 nerve root. The 2/27/13 spine surgery second opinion indicated the patient might be a candidate for microdiscectomy at L5-S1, but there were no significant imaging findings to support providing the procedure at L4-5. The consultant noted significant symptom magnification, suggesting a nonorganic component to her complaints. The 1/6/14 treating physician report noted completion of 12 acupuncture visits which helped decrease her pain. Subjective complaints included grade 5-8/10 low back pain with radiation of pain and numbness and tingling in the bilateral lower extremities to her feet. There was a slight increase in symptoms that she attributed to not having her medications that she lost three months ago. Objective findings documented bilateral thigh atrophy, antalgic gait, abnormal heel and toe walk on the left, diffuse paralumbar tenderness to palpation, decreased range of motion, and decreased L3-S1 dermatomal sensation. Left lower extremity muscle strength was 4/5 globally, right was 5-/5 globally. Straight leg raise was positive on the right. There was positive slump text and Lasegue's sign bilaterally.

IMR ISSUES, DECISIONS AND RATIONALES

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

Microlumbar Decompression Surgery on the Left Lumbar 4-5 and Lumbar 5 - Sacral 1
QTY: 1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 127.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 302-303.

Decision rationale: The ACOEM guidelines recommend lumbar discectomy as an effective operation to speed recovery in 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. Indications include radicular pain syndrome with current dermatomal pain and/or numbness, or myotomal muscle weakness all consistent with a herniated disc, and imaging findings that confirm persistent nerve root compression at the level and on the side predicted by history and clinical exam. Surgical criteria require documentation of continued significant pain and functional limitations after 4 to 6 weeks of time and appropriate conservative therapy. Discectomy is not recommended for treatment of chronic lower back pain without radiculopathy. Guideline criteria have not been met. The current clinical exam findings documented global lower extremity weakness and sensory loss, which is not fully correlated with imaging findings. There is no detailed documentation that recent comprehensive pharmacologic and non-pharmacologic conservative treatment had been tried and failed. A recent increase in symptoms is reported secondary to loss of medication. There is no evidence of failure of therapeutic injections or attempted diagnostic injections. A second surgical opinion did not agree with the inclusion of the L4-5 level, if surgery was to be performed. A current second surgical opinion has been requested and certified. Therefore this request is not medically necessary.

Postoperative Physiotherapy to the lumbar spine two (2) times a week for six (6) weeks
QTY: 12: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 2-3, 15-16.

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.

Additional Acupuncture to the lumbar spine two (2) times a week for four (4) weeks
QTY:8: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The California MTUS Acupuncture Medical Treatment Guidelines indicate that acupuncture may be used as an option when pain medication is reduced or not tolerated, and it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. Guidelines state that 3 to 6 treatments allow time to produce functional improvement. Acupuncture treatments may be extended if functional improvement is documented as defined in the guidelines. Guideline criteria have not been met. The acupuncture chart notes cited patient report of improved ability to perform activities of daily living but indicated there was no change in condition. There is no documentation of functional improvement consistent with the MTUS definition. Functional improvement is defined as either a clinically significant improvement in activities of daily living or a reduction in work restrictions; and a reduction in the dependency on continued medical treatment. Given the absence of functional improvement consistent with guidelines, this request is not medically necessary.

Internal Medicine Consultation regarding Gastrointestinal (GI) complaints QTY: 1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 127.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Independent Medical Examinations and Consultations (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 7), page 127.

Decision rationale: The ACOEM guidelines support referral to a specialist if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. Guideline criteria have not been met. There is no clear indication of what gastrointestinal symptoms the patient is having and how they relate to medication use, as she reported non-use of medications for the prior 3 months. There are no documented risk factors for gastrointestinal events. Therefore, this request is not medically necessary.