

Case Number:	CM14-0075532		
Date Assigned:	07/16/2014	Date of Injury:	10/05/2011
Decision Date:	08/14/2014	UR Denial Date:	05/01/2014
Priority:	Standard	Application Received:	05/23/2014

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 male truck driver sustained an industrial injury on 10/5/11. Injury occurred when he slipped off a truck ladder and fell, hitting his face on the ladder with injury to his teeth, neck, and lower back. The 8/17/13 lumbar MRI impression documented far lateral recess disc protrusion at L3/4 encroaching upon the exiting left L3 nerve root and moderate to severe right neuroforaminal stenosis. At L5/S1, there was severe bilateral neuroforaminal stenosis, severe facet arthropathy, and moderate to severe disc disease. Multilevel disc bulges were noted with annular tear at L4/5. There were cystic degenerative changes along the superior aspect of the L4 posterior spinous process, likely from chronic abutment. The treating physician progress reports from 11/25/13 to 3/26/14 cited continued complaints of low back pain radiating down his left leg. Physical exams documented range of motion limited to flexion 30, extension 20, and right/left lateral flexion 20 to 30 degrees. Straight leg raise was negative bilaterally. Lower extremity neurologic exam was intact. A left L5/S1 micro lumbar discectomy and foraminotomy was recommended. Reconsideration of the lumbar epidural steroid injection was requested on 3/26/14. Medications were dispensed monthly. No other conservative treatment was documented. The 5/1/14 utilization review denied the request for lumbar surgery and associated services based on an absence of documented motor, sensory or reflex deficits or dermatomal patterned paresthesias in the L5 or S1 distribution on the left. There was severe bilateral foraminal stenosis noted on MRI, it was unclear how a left approach would address the right-sided severe stenosis.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left L5-S1 micro lumbar discectomy and foraminotomy: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 195-199.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 202-208.

Decision rationale: The ACOEM Revised Low Back Disorder guidelines recommend 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. Guidelines recommend decompression surgery as an effective treatment for patients with symptomatic spinal stenosis (neurogenic claudication) that is intractable to conservative management. Guideline 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 4 to 6 weeks of time and appropriate conservative therapy. Guideline criteria have not been met. There is no documentation of radicular pain in a dermatomal pattern. There is no clinical evidence of neural compression. Lower extremity strength, reflexes, sensation, and nerve tension signs are normal. There is no detailed documentation that recent comprehensive pharmacologic and non-pharmacologic conservative treatment had been tried and failed. Therefore, this request for left L5-S1 micro lumbar discectomy and foraminotomy is not medically necessary.

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.

Post-operative corset 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.