

Case Number:	CM14-0075545		
Date Assigned:	08/08/2014	Date of Injury:	08/13/2013
Decision Date:	09/11/2014	UR Denial Date:	04/30/2014
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 and Spine Surgery and is licensed to practice in New York. 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 patient has a date of injury of August 13, 2013. The patient has chronic low back pain. Physical examination showed multilevel mild left-sided sensory abnormalities in the left leg and weakness of right-sided ankle dorsiflexion. No left-sided weakness is documented. Straight leg raising is positive on the left and negative on the right. Lumbar MRI shows 4 mm L4-5 disc protrusion and 6 mm L5-S1 disc protrusion. At issue is whether lumbar decompressive surgery is medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left L5-S1 Laminectomy, Lateral Recess Decompression: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-322.

Decision rationale: Since surgery is not medically necessary, then all other associated items are not needed. This patient does not meet establish criteria for lumbar decompressive surgery. Specifically there is no clear correlation between physical examination showing specific lumbar radiculopathy and imaging studies showing specific compression of the lumbar nerve root. In addition the patient does not have any red flag indicators for spinal decompressive surgery such

as progressive neurologic deficit, fracture, tumor, or instability therefore lumbar decompressive surgery not medically necessary.

Random Urine Drug Screen: Upheld

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

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: MTUS Chronic Pain Treatment Guidelines.

Decision rationale: The patient's risk of narcotic abuse is unknown and random urine drug screen is not recommended. The medical records do not document any evidence of potential narcotic abuse. In addition, narcotics are not recommended for long-term using chronic low back pain patients therefore Urine Toxicology Screen is not medically necessary.

Lumbar-Sacral Orthosis (LSO): Upheld

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

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: ODG Low Back Pain.

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

Pneumatic Intermittent Compression Device: Upheld

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

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.

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

Post operative Clearance w/ Chest X-ray (CXR) and EKG: 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.

Follow-up in four to six weeks: 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.

Postoperative Physical Therapy x 18: 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.