MAXIMUS Federal Services

Case Number:	CM14-0096811		
Date Assigned:	07/23/2014	Date of Injury:	08/17/2012
Decision Date:	09/24/2014	UR Denial Date:	06/06/2014
Priority:	Standard	Application Received:	06/06/2014

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 is a 19 year old female with an 8/17/12 injury date. She was sitting in the break room and a co-worker moved her chair causing her to fall on the floor. She felt instant pain in her low back and then gradually experienced radiating pain to both legs with numbness and tingling. She had a lumbar ESI (epidural steroid injection) about one year ago with no relief. She has tried 6 months of physical therapy, also without relief. Current subjective complaints as of 5/21/14 are continued low back pain with radiation into both lower extremities. Objective findings include difficulty walking on her toes, normal heel walking, diffusely diminished sensation in bilateral lower extremities, intact reflexes, one centimeter of atrophy in the right calf compared to the left. There are positive straight leg raise tests and bowstring signs bilaterally. MRI of the lumbar spine on 11/5/12 shows a large disc herniation at L4-5 which severely compresses the dural sac, and a smaller disc herniation at L5-S1. Diagnostic impression: L4-5 lumbar herniated nucleus pulposus. Treatment to date: physical therapy, epidural steroid injection, medication management, TENS (transcutaneous electrical nerve stimulation) unit.A prior UR decision dated 6/5/14 approved the request for right L4-5 microdiscectomy but denied the request for right L4-5 laminotomy on the basis that it was not medically necessary. This decision also denied the request for pre-op visit with an internist on the basis that there was no rationale provided for this otherwise healthy appearing 19 year old female.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right L4-L5 Laminectomy: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Indications for surgery, Discectomy/Laminectomy.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Low Back Chapter.

Decision rationale: CA MTUS states that surgical intervention is recommended for patients who have severe and disabling lower leg symptoms in the distribution consistent with abnormalities on imaging studies (radiculopathy), preferably with accompanying objective signs of neural compromise; activity limitations due to radiating leg pain for more than one month or extreme progression of lower leg symptoms; clear clinical, imaging, and electrophysiologic evidence of a lesion that has been shown to benefit in both the short and long- term from surgical repair; and failure of conservative treatment. Direct methods of nerve root decompression include laminotomy, standard discectomy, and laminectomy. In the present case, the discectomy portion was already approved. Since performing a laminectomy is generally part of the decompression procedure as a whole, this too, can be certified. The patient exhibits symptoms and signs that corroborate with the imaging studies and has also failed a significant trial of conservative management. Therefore, the request for right L4-5 laminectomy is medically necessary.

Inpatient hospital stay, 3-5 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, hospital length of stay.

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 Chapter.

Decision rationale: CA MTUS does not address this issue. ODG guidelines for hospital length of stay (LOS) for discectomy cite a median stay of 1 day with a mean of 2.1 days. For laminectomy, the guidelines cite a median stay of 2 days with a mean of 3.5 days. Based upon this, it is difficult to justify a 3-5 day length of stay for a 19 year old patient. Therefore, the request for inpatient hospital stay, 3-5 days, is not medically necessary.

Pre-operative visit with internist: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACC/AHA 2007 Guidelines on Perioperative Cardiovascular Evaluation and Care for Non-cardiac Surgery.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation The Expert Reviewer based his/her decision on the Non-

MTUS Official Disability Guidelines (ODG): ODG (Low Back - Lumbar & Thoracic (Acute & Chronic) Chapter -Preoperative EKG and Lab testing) and on Other Medical Treatment Guideline or Medical Evidence: ACC/AHA (American College of Cardiology/American Heart Association) 2007 Guidelines on perioperative cardiovascular evaluation and care for non-cardiac surgery.

Decision rationale: CA MTUS does not address this issue. ODG states that pre-op testing can be helpful to stratify risk, direct anesthetic choices, and guide postoperative management, but often are obtained because of protocol rather than medical necessity. The decision to order preoperative tests should be guided by the patient's clinical history, comorbidities, and physical examination findings. Patients with signs or symptoms of active cardiovascular disease should be evaluated with appropriate testing, regardless of their preoperative status. Electrocardiography is recommended for patients undergoing high-risk surgery and those undergoing intermediate-risk surgery who have additional risk factors. Patients undergoing low-risk surgery do not require electrocardiography. Chest radiography is reasonable for patients at risk of postoperative pulmonary complications if the results would change perioperative management. The ACC/AHA 2007 Guidelines on perioperative cardiovascular evaluation and care for noncardiac surgery state that in the asymptomatic patient, a more extensive assessment of history and physical examination is warranted in those individuals 50 years of age or older. In the present case, there is no information or rationale provided to justify pre-operative medical clearance for this 19 year old patient. Therefore, the request for pre-operative visit with internist is not medically necessary.