

Case Number:	CM14-0189718		
Date Assigned:	11/21/2014	Date of Injury:	08/22/2012
Decision Date:	01/09/2015	UR Denial Date:	10/27/2014
Priority:	Standard	Application Received:	11/14/2014

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 Surgeon and Fellowship Trained Spine Surgeon and is licensed to practice in New Jersey. 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 injured worker is a 46-year-old male who reported an injury on 08/22/2012. The mechanism of injury was not submitted for clinical review. His diagnoses included spinal stenosis of lumbar region, degenerative disc disease of lumbar or lumbosacral. Previous treatments included medication, physical therapy, and 2 epidural steroid injections. On 09/29/2014, it was reported the injured worker complained of back pain and discomfort. The physical examination revealed limited range of motion. The provider noted weakness of the hip flexor, 4/5 on the right and 5/5 on the left. The provider noted the injured worker to have a positive tension sign on the right side. The provider requested a microdiscectomy at L1-2 on the right side, preoperative labs, CBC, CMP, EKG, and chest x-ray. However, a rationale was not submitted for clinical review. The request for authorization was submitted and dated on 09/30/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Microdiscectomy L1-2 Right Side: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-306.

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, Discectomy/ laminectomy.

Decision rationale: The California Medical Treatment Utilization Schedule (MTUS)/ American College of Occupational and Environmental Medicine (ACOEM) Guidelines state surgical consideration is recommended for individuals with severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging, activity limitations due to radiating leg pain for more than 1 month, and extreme progression of lower leg symptoms, clear clinical, imaging and electrophysiological evidence of a lesion that has been shown to benefit in both long and short term from surgical repair and failure of conservative treatment to resolve disabling radicular symptoms. In addition, the Official Disability Guidelines note standard discectomies and microdiscectomies are of similar efficacy in treatments of herniated discs. The guidelines recommend symptoms and findings confirm the presence of radiculopathy. Objective findings on examination need to be present, including a positive straight leg raise, crossed straight leg raise, and reflex exams should correlate with symptoms and imaging. Conservative treatment for at least 2 months, which include activity modification, medication, muscle relaxants, and epidural steroid injections. The clinical documentation submitted lacks significant objective findings of radiculopathy on physical examination. There is a lack of documentation indicating the injured worker had an adequate trial of conservative therapy for at least 2 months. There was a lack of documentation of imaging studies corroborating the diagnosis warranting the medical necessity for the request. Therefore, the request is not medically necessary.

Associates Surgical Services: Per-Operative Labs; CBC, CMP, EKG, Chest X-ray: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG (Low Back - Lumbar & Thoracic (Acute & Chronic) Chapter)

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, Preoperative electrocardiogram, Preoperative lab testing, preoperative testing general.

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