

Case Number:	CM14-0194779		
Date Assigned:	12/02/2014	Date of Injury:	06/15/2012
Decision Date:	01/14/2015	UR Denial Date:	10/30/2014
Priority:	Standard	Application Received:	11/20/2014

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 Spine Surgery and is licensed to practice in Texas. 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 47-year-old male who reported an injury on 06/15/2012. The mechanism of injury was not provided. On 11/11/2014, the injured worker had a chief complaint of low back and leg pain. His diagnosis was disc herniation at the level of the L3-4. Prior therapies included epidural steroid injection that minimally relieved his symptoms. Medications included Percocet. The provider noted that the patient continued to have severe debilitating symptoms and wished to proceed with surgery. The patient is noted to have 4/5 strength to the right tibialis anterior compared to 5/5 strength in the tibialis anterior at the left. There is intact sensation to light touch bilaterally for the right anterior knee. The patient continued to have pain that shoots from the right side to the back into his right buttock. He was also noted to have continued numbness over the right anterior knee. The provider recommended an L2-3 hydro decompression and L3-4 microdisectomy; the rationale was not provided. The Request for Authorization form was not included in the medical documents for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

L2-3 hydro decompression & L3-4 microdisectomy: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 306. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Spinejet (HydroCision)

Decision rationale: The request for decision for L2-3 hydro decompression and L3-4 microdiscectomy is not medically necessary. The California MTUS/ACOEM Guidelines state that a surgical discectomy for carefully selected patients with nerve root compression due to lumbar disc prolapse provides faster relief from the acute intact than conservative management, but any positive or negative effects on the lifetime natural history of underlying disc disease are still unclear. Micro discectomy has not been adequately proven with regard to overall efficacy and safety. Hydro decompression is not recommended. This device is used during lumbar fusion or percutaneous discectomy, which are not recommended in the ODG. There is only one published study. The patient is noted to have 4/5 strength to the right tibialis anterior compared to 5/5 strength in the tibialis anterior at the left. There is intact sensation to light touch bilaterally for the right anterior knee. However, there is limited long term references that reveal safety and efficacy of the requested procedure. There are no indications that the proposed procedure would result in improved health outcomes. Therefore, the request is not medically necessary.