

Case Number:	CM14-0198443		
Date Assigned:	12/08/2014	Date of Injury:	01/15/2014
Decision Date:	01/23/2015	UR Denial Date:	11/13/2014
Priority:	Standard	Application Received:	11/25/2014

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 Pennsylvania. 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 34-year-old male who reported injury on 01/15/2014. The mechanism of injury was not submitted for review. The injured worker has diagnoses of unspecified thoracic/lumbar neuritis and lumbago. Past medical treatment consists of epidural steroid injections, trigger point injections, and medication therapy. Medications include Ibuprofen 600mg to 800mg. It was noted in progress report dated 11/06/2014 that the injured worker underwent an MRI on 02/05/2014. The MRI was not submitted for review. On 11/06/2014, the injured worker complained of lumbar spine pain. Physical examination of the lumbar spine revealed -25 -15 of flexion/extension/right lateral bending. Positive straight leg raise along the right L4 dermatome was noted. Toe heel walk was difficult due to right L4 dermatome motor sensory deficits. Positive trigger points, right greater than left, of the lumbar spine were noted. The treatment plan was for the injured worker to undergo discectomy at L4-S1. The rationale and Request for Authorization form were not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

L4-S1 minimally invasive percutaneous discectomy and any repairs: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

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, Discectomy/laminectomy

Decision rationale: The request for L4-S1 minimally invasive percutaneous discectomy and any repairs is not medically necessary. The Official Disability Guidelines recommend surgical discectomy for carefully selected patients with radiculopathy due to lumbar disc prolapse. The submitted documentation failed to indicate presence of radiculopathy. There was no indication of the injured worker having any nerve root compression. There were no imaging studies submitted for review to corroborate a diagnosis of radiculopathy. There was also no evidence of the injured worker having failed conservative treatment. Furthermore, the submitted documentation failed to indicate objective physical findings. Given the above, the request is not within recommended guideline criteria. As such, the request is not medically necessary.

Associated surgical service: Labs: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, 19th Edition, Low Back Chapter, Preoperative lab testing

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.

Associated surgical service: Post-Operative Physical Therapy 3 times a week for 3 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 25-26.

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.