MAXIMUS Federal Services

Case Number:	CM14-0204921		
Date Assigned:	12/17/2014	Date of Injury:	04/14/2011
Decision Date:	02/09/2015	UR Denial Date:	12/01/2014
Priority:	Standard	Application Received:	12/08/2014

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, has a subspecialty in Spine 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:

The injured worker is a 52-year-old male who reported injuries due to cumulative trauma on 04/14/2011. On 11/18/2014, his diagnoses included L4-5 and L5-S1 stenosis and left leg radiculopathy. His complaints included left paraspinal pain rated 1-5/10 with numbness in the left shin to the top of the foot. He had an episode of right paraspinal pain 2 weeks previously, which gradually resolved spontaneously. His lumbar spine ranges of motion measured in degrees were flexion 42/60, extension 20/25, left lateral bend 10/25, and right lateral bend 12/35, with pain in all planes. On 06/30/2014, he underwent an L4-5 and L5-S1 selective nerve root block with lumbar epidurogram. On 07/17/2014, he underwent therapeutic medial branch blocks to the lumbar facets at L4-5 and L5-S1. On 08/26/2014, there was no palpable tenderness of the paravertebral muscles or evidence of tenderness over the sacroiliac joints. A previous epidural steroid injection provided temporary improvement. Physical therapy and chiropractic treatments failed to provide symptomatic relief. An MRI of the lumbar spine on 10/09/2014 noted that impingement potential is substantial at L4-5, where there was a moderate left and mild to moderate right lateral recess stenosis caused by a 3 to 5 mm left greater than right posterolateral disc protrusion with opposing mild to moderate left and mild right sided ligamentous thickening/facet arthropathy. Ample potential existed for symptomatic impingement upon the descending left L5 nerve root. There was a recommendation for a clinical correlation. There was mild left greater than right sided L4 foraminal narrowing and mild bilateral L5 foraminal narrowing. Based upon his ongoing symptoms and failure to improve with conservative measures, including lifestyle modifications, medications including NSAIDs, chiropractic therapy, and physiotherapy, and the lumbar epidural steroid injection, which provided only temporary improvement, the recommendation was made for the requested surgical procedure. A Request for Authorization dated 11/18/2014 was included in this injured worker's chart.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left L4-L5 Laminotomy and Foraminotomy, lateral recess decompression and possible microdiscectomy, quantity 1.00: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307.

Decision rationale: The request for left L4-L5 Laminotomy and Foraminotomy, lateral recess decompression and possible microdiscectomy, quantity 1.00 is not medically necessary. The California ACOEM Guidelines note that disc herniation may impinge on a nerve root, causing irritation, back and leg symptoms, and nerve root dysfunction. The presence of a herniated disc on an imaging study; however, does not necessarily imply nerve root dysfunction. Studies of asymptomatic adults commonly demonstrate intervertebral disc herniations that apparently do not cause symptoms. Some studies show spontaneous disc resorption without surgery, while others suggest that pain may be due to irritation of the dorsal root ganglion by inflammogens released from a damaged disc. Therefore, referral for surgical consultation is indicated for patients who have severe and disabling lower leg symptoms in a 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 1 month or extreme progression of lower leg symptoms, clear clinical, imaging, and electrophysiological evidence of a lesion that has been shown to benefit in both the short and long term from surgical repair. If surgery is a consideration, counseling regarding likely outcomes, risks and benefits, and especially expectations, is very important. Patients with acute low back pain alone, without findings of serious conditions or significant nerve root compromise, rarely benefit from either surgical consultation or surgery. Before referral for surgery, clinicians should consider referral for psychological screening to improve surgical outcomes, possibly including standardized tests such as the MMPI 2. With or without surgery, more than 80% of patients with apparent surgical indications eventually recovery. Although surgery appears to speed short to midterm recovery, surgical morbidity and complications must be considered. Surgery benefits fewer than 40% of patients with questionable physiologic findings. Moreover, surgery increases the need for future surgical procedures with higher complication rates. Although this injured worker's MRI noted that ample potential exists for symptomatic impingement upon the descending left L5 nerve root, there was a recommendation for clinical correlation. There was no electrophysiological evidence submitted confirming evidence of a lesion that would benefit from surgical repair. There was no documentation submitted of a psychological screening of this injured worker. It was noted that he had a previous spontaneous resolution of paraspinal pain. The clinical information submitted failed to meet the evidence based guidelines for the requested surgery. Therefore, this request for left L4-L5 Laminotomy and Foraminotomy, lateral recess decompression and possible microdiscectomy, quantity 1.00 is not medically necessary.

Left L5-S1 Laminotomy quantity 1.00: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307.

Decision rationale: The request for left L5-S1 Laminotomy quantity 1.00 is not medically necessary. The California ACOEM Guidelines note that disc herniation may impinge on a nerve root, causing irritation, back and leg symptoms, and nerve root dysfunction. The presence of a herniated disc on an imaging study; however, does not necessarily imply nerve root dysfunction. Studies of asymptomatic adults commonly demonstrate intervertebral disc herniations that apparently do not cause symptoms. Some studies show spontaneous disc resorption without surgery, while others suggest that pain may be due to irritation of the dorsal root ganglion by inflammogens released from a damaged disc. Therefore, referral for surgical consultation is indicated for patients who have severe and disabling lower leg symptoms in a 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 1 month or extreme progression of lower leg symptoms, clear clinical, imaging, and electrophysiological evidence of a lesion that has been shown to benefit in both the short and long term from surgical repair. If surgery is a consideration, counseling regarding likely outcomes, risks and benefits, and especially expectations, is very important. Patients with acute low back pain alone, without findings of serious conditions or significant nerve root compromise, rarely benefit from either surgical consultation or surgery. Before referral for surgery, clinicians should consider referral for psychological screening to improve surgical outcomes, possibly including standardized tests such as the MMPI 2. With or without surgery, more than 80% of patients with apparent surgical indications eventually recovery. Although surgery appears to speed short to midterm recovery, surgical morbidity and complications must be considered. Surgery benefits fewer than 40% of patients with questionable physiologic findings. Moreover, surgery increases the need for future surgical procedures with higher complication rates. Although this injured worker's MRI noted that ample potential exists for symptomatic impingement upon the descending left L5 nerve root, there was a recommendation for clinical correlation. There was no electrophysiological evidence submitted confirming evidence of a lesion that would benefit from surgical repair. There was no documentation submitted of a psychological screening of this injured worker. It was noted that he had a previous spontaneous resolution of paraspinal pain. The clinical information submitted failed to meet the evidence based guidelines for the requested surgery. Therefore, this request for left L5-S1 Laminotomy quantity 1.00 is not medically necessary.

Associates Surgical Services: LSO brace: 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.

Associates Surgical Services: Pre-operative medical clearance, quantity 1.00: 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.

Associates Surgical Services: Post-operative physiotherapy, quantity 1.00: 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: As the requested surgical intervention is not supported by the documentation, the requested ancillary service is also not supported.

Associates Surgical Services: Post-Operative DME Pneumatic Compression Device, quantity 1.00: 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.

Associates Surgical Services: Assistant surgeon, quantity 1.00: 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.