

Case Number:	CM15-0000144		
Date Assigned:	01/09/2015	Date of Injury:	03/27/2013
Decision Date:	03/17/2015	UR Denial Date:	12/31/2014
Priority:	Standard	Application Received:	12/31/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: New York
 Certification(s)/Specialty: Neurological Surgery

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

CA IMR Expert Review CM15-0000144 3/7/15 This 52 year old male had lumbar fall on his back in 1995 after which he settled a claim with a lump sum. He claimed injuries from repetitive motion in his employment from 2002 to reported date of injury March 27, 2013. He was initially seen for low back pain, treated with physical therapy, and medications. In April of 2013, a diagnosis was made of right shoulder impingement, right carpal tunnel syndrome, cervical degenerative disc disease, lumbar herniated disc, and right elbow lateral epicondylitis. After consultation with pain management, he received epidural injections for the low back and a right lumbar radiculopathy. On July 12, 2013, underwent a right shoulder arthroscopy and carpal tunnel release. His lumbar MRI on 07/10/2014 showed a 4-5 mm left posterior paracentral disc herniation responsible for minimal left L5-S1 lateral recess stenosis posteriorly displacing the S1 nerve root and an annular tear. His EMG's and NCVs of the legs on 07/10/2014 were normal. Evaluation with the Agreed Upon Medical Examiner on 07/24/2014 showed no weakness in his legs, surgery was not advised, but repeat epidural steroid injections were. His PR2 of 07/29/2014 noted he had back pain radiating into the right leg and was using a cane. He had a positive right straight leg raising test, limited range of motion of the back. On October 9, 2014, according to a primary treating physician's final report, the injured worker presented with complaints of neck pain with radiation to the posterior aspect of the right shoulder, elbow and hand, rated 7/10. The pain increases with tilting up and down and turning his head side to side. There is also numbness and tingling present in both hands. Diagnoses are lumbago; radiculitis, lumbar radiculopathy. Treatment plan included authorization for L5-S1 Bilateral Micro-

decompression and associated services. According to utilization review performed December 31, 2014, the request for L5-S1 Bilateral Micro-decompression surgery is non-certified citing MTUS ACOEM Guidelines. The request for an Assistant Surgeon is non-certified. The request for Pre-Operative Medical Clearance is non-certified. The request for Post-Op PT 2 x a week for 6 weeks, 12 sessions are non-certified. The request for Post-Op DME; 3 in 1 Commode is non-certified. The request for Post-Op DME; Standard Lumbar Brace is non-certified. The request for Post-Op DME Walker is non-certified. The request for Home Care 2 hours/day 6 days/week for 2 weeks is non-certified. The request for Transportation to and from doctor's appointments after surgery is non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

L5-S1 bilateral micro-decompression surgery: Upheld

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

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

Decision rationale: According to the CA MTUS guidelines in chapter 12 Low Back Complaints(p305-)Surgical considerations: Surgical consultation is indicated if the injured worker has severe and disabling leg symptoms which are consistent with the imaging studies. This injured worker's disc herniation is on the left at L5-S1, not the right where he has been complaining. Consultation is indicated with there is electrophysiological evidence of a lesion. The injured worker's EMG and NCV's were normal on 07/10/2014. Moreover, the guidelines indicate that surgical consultation is indicated when workers have failed conservative treatment. Documentation is not provided which proves this is the case. According to ODG Guidelines (Low Back Chapter-Discectomy/laminectomy) unequivocal objective evidence of radiculopathy and testing is recommended for discectomy/laminectomy. The MRI scan of the lumbar spine reports that the left posterior paracentral 4-5 mm disc herniation at L5-S1 is not producing thecal sac compromise but is producing minimal lateral recess stenosis displacing the S1 nerve root. Since this is on the left a bilateral decompression would not be necessary. EMGs and NCVs are normal in the lower extremities and do not provide unequivocal evidence of radiculopathy.

Assistant surgeon: 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.

Post-operative physical therapy, twice a week for six weeks: 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.

Post-operative DME 3 in 1 Commode: 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.

Post-operative standard lumbar 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.

Post-operative Walker: 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.

Associated surgical services: In Home Care two hrs per day at six days per week for two weeks: 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.

Associated surgical services: Transportation to and from appointments, after surgery:
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.