

Case Number:	CM15-0002525		
Date Assigned:	01/13/2015	Date of Injury:	07/05/2012
Decision Date:	03/23/2015	UR Denial Date:	12/12/2014
Priority:	Standard	Application Received:	01/06/2015

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: Minnesota, Florida
Certification(s)/Specialty: Orthopedic 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:

The injured worker is a 48 year old male who sustained an industrial injury on 7/5/2013. He has reported a trip and fall, injuring his low back and left knee. The diagnoses have included lumbar herniated nucleus pulposus, low back pain, lumbar degenerative disc disease and sciatica. Treatment to date has included physical therapy, lumbar steroid injections and medication management. Currently, the IW complains of low back pain and left lower extremity pain. Magnetic resonance imaging showed a bulging disc at lumbar 4-5 with facet arthropathy. Treatment plan included lab panel, chest x ray, electrocardiogram, one night hospital stay and a left lumbar 4-5 microdiscectomy with neural foraminotomy. On 12/12/2014, Utilization Review non-certified the left lumbar 4-5 microdiscectomy with neural foraminotomy, noting the lack of physical therapy documentation to show all conservative measures have been exhausted. Official Disability Guidelines were cited. The lab panel, chest x ray, electrocardiogram and one night hospital stay were also noncertified, noting the lack of medical necessity due to non-certified surgery.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left L4-5 microdiscectomy with neural foraminotomy: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter Surgical Considerations, Indications for surgery - Discectomy/laminectomy

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

Decision rationale: The injured worker meets the guideline requirements for a left L4-5 microdiscectomy with neural foraminotomy. He has had extensive conservative treatment including medications, epidural steroid injections, and physical therapy. The MRI findings of a herniation at L4-5 on the left extending into the neural foramen and compressing the nerve roots correlates with the positive straight leg raising on the left, decreased sensation in the L4-5 dermatomal distribution. The utilization review denial was based upon absence of documentation of physical therapy. The medical records indicate physical therapy was tried for approximately a year starting in July 2012 through May 2013 2-3 times a week with no long-term benefit. The injured worker meets the California MTUS as well as ODG criteria for a lumbar microdiscectomy with nerve root decompression. The California MTUS guidelines indicate that surgical discectomy for carefully selected patients with nerve root compression due to lumbar disc prolapse provides faster relief from the acute attack than conservative management. The injured worker has had extensive conservative management and it is not likely that any additional improvement will result without surgical intervention. In light of the above, the guideline criteria have been met and the medical necessity of the requested L4-5 microdiscectomy and neural foraminotomy on the left is established.

Associated surgical services: Lab panel: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back, Topic, Preoperative lab testing

Decision rationale: The ODG criteria for preoperative lab testing are based upon comorbidities. Electrolyte and creatinine testing should be performed in patients with underlying chronic disease and those taking medications that predispose them to electrolyte abnormalities or renal failure. Random glucose testing should be performed in patients at high risk of undiagnosed diabetes mellitus. In patients with known diagnosis of diabetes A1c testing is recommended if the results will change perioperative management. The documentation submitted does not mention any significant comorbidities. The request as submitted is for preoperative labs which is vague and does not specify what testing is requested. As such, the medical necessity of the request cannot be determined.

Associated surgical services: Chest x-ray: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back, Topic, Preoperative testing, general

Decision rationale: ODG guidelines indicate that the decision to order preoperative tests should be guided by patient's clinical history, comorbidities, and physical examination findings. Chest radiography is reasonable for patients at risk of postoperative pulmonary complications if the results would change perioperative management. As such, a routine chest x-ray is not necessary. Based upon the guidelines, the request for a preoperative chest x-ray is not supported and the medical necessity is not established.

Associated surgical services: One night hospital stay: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, hospital length of stay (LOS) guidelines

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back, Topic, Hospital length of stay

Decision rationale: ODG guidelines indicate for laminectomy/laminotomy for decompression of spinal nerve root the median length of stay is 2 days and best practice target is 1 day. The request as submitted for 1 day hospital stay is supported by guidelines and as such, the medical necessity is established.

Associated surgical services: EKG: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Preoperative electrocardiogram (ECG)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back, Topic, Preoperative electrocardiogram

Decision rationale: The operative procedure is classified as an intermediate risk surgical procedure. ODG guidelines indicate preoperative electrocardiogram for intermediate risk procedures in the presence of risk factors such as known ischemic heart disease, history of compensated or prior heart failure, or history of cerebrovascular disease, diabetes or renal insufficiency. The documentation does not indicate presence of these risk factors and as such the request for electrocardiography is not supported by guidelines and the medical necessity is not established.

