

Case Number:	CM15-0104585		
Date Assigned:	06/08/2015	Date of Injury:	12/03/2011
Decision Date:	07/14/2015	UR Denial Date:	04/27/2015
Priority:	Standard	Application Received:	06/01/2015

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: New Jersey, Alabama, California
 Certification(s)/Specialty: Neurology, Neuromuscular Medicine

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 patient who sustained an industrial injury on 12/03/2011. A primary treating office visit dated 05/05/2015 reported subjective complaint of continued low back pain and stiffness. Objective findings showed tenderness in the lower lumbar paravertebral musculature. Forward flexion is to 45 degrees, extension to 10 degrees, lateral bending to 30 degrees. He is diagnosed with discogenic low back pain. The plan of care noted the patient to obtain a urine drug screen, and return for a follow up visit. He is prescribed Norco 7.5/325mg and he is temporary totally disabled. Current medications consist of: Ambien, Tramadol, ASA, Citalopram, Amlodipine, and Pantoprazole. A magnetic resonance imaging study done on 08/19/2013 showed L2 to L5 multi-level lumbar spine stenosis. The following diagnoses are applied: lumbar spinal stenosis and lumbar degenerative disc disease. On 06/16/2015 recommendation was made for the patient to undergo lumbar laminectomy. He is to remain on temporary totally disability.

IMR ISSUES, DECISIONS AND RATIONALES

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

Laminectomy, L3-S1, possible fusion: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Discectomy/ laminectomy.
<http://www.odg-twc.com/index.html>.

Decision rationale: According to ODG guidelines, indication for lumbar laminectomy: ODG Indications for Surgery Discectomy/laminectomy: Required symptoms/findings; imaging studies; & conservative treatments below: I. Symptoms/Findings which confirm presence of radiculopathy. Objective findings on examination need to be present. Straight leg raising test, crossed straight leg raising and reflex exams should correlate with symptoms and imaging. Findings require ONE of the following: A. L3 nerve root compression, requiring ONE of the following: 1. Severe unilateral quadriceps weakness/mild atrophy 2. Mild-to-moderate unilateral quadriceps weakness 3. Unilateral hip/thigh/knee pain B. L4 nerve root compression, requiring ONE of the following: 1. Severe unilateral quadriceps/anterior tibialis weakness/mild atrophy 2. Mild-to-moderate unilateral quadriceps/anterior tibialis weakness 3. Unilateral hip/thigh/knee/medial pain C. L5 nerve root compression, requiring ONE of the following: 1. Severe unilateral foot/toe/dorsiflexor weakness/mild atrophy 2. Mild-to-moderate foot/toe/dorsiflexor weakness 3. Unilateral hip/lateral thigh/knee pain D. S1 nerve root compression, requiring ONE of the following: 1. Severe unilateral foot/toe/plantar flexor/hamstring weakness/atrophy 2. Moderate unilateral foot/toe/plantar flexor/hamstring weakness 2. Unilateral buttock/posterior thigh/calf pain (EMGs are optional to obtain unequivocal evidence of radiculopathy but not necessary if radiculopathy is already clinically obvious.) II. Imaging Studies, requiring ONE of the following, for concordance between radicular findings on radiologic evaluation and physical exam findings: A. Nerve root compression (L3, L4, L5, or S1) B. Lateral disc rupture C. Lateral recess stenosis Diagnostic imaging modalities, requiring ONE of the following: 1. MR imaging 2. CT scanning 3. Myelography 4. CT myelography & X-Ray III. Conservative Treatments, requiring ALL of the following: A. Activity modification (not bed rest) after patient education (> = 2 months) B. Drug therapy, requiring at least ONE of the following: 1. NSAID drug therapy 2. Other analgesic therapy 3. Muscle relaxants 4. Epidural Steroid Injection (ESI) C. Support provider referral, requiring at least ONE of the following (in order of priority): 1. Physical therapy (teach home exercise/stretching) 2. Manual therapy (chiropractor or massage therapist) 3. Psychological screening that could affect surgical outcome 4. Back school (Fisher, 2004). For average hospital LOS after criteria are met, see Hospital length of stay (LOS). There is no recent clinical, radiological and electrodiagnostic evidence lumbar root compression in this case. There is no recent and objective documentation of failure of conservative therapies and injections. Therefore, the request for Laminectomy, L3-S1, possible fusion is not medically necessary.

Pre-operative labs: Urinalysis (UA), Complete Blood Count (CBC), Prothrombin Time (PT)/Partial Thromboplastin Time (PTT): 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.

Pre-op Electrocardiography (EKG): 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.

Pre-op 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 X ray Chest. <http://www.odg-twc.com/index.html>.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Associated surgical service: medical clearance fro internal medicine doctor: 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.