

Case Number:	CM15-0146380		
Date Assigned:	08/07/2015	Date of Injury:	06/16/2004
Decision Date:	09/08/2015	UR Denial Date:	07/13/2015
Priority:	Standard	Application Received:	07/28/2015

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: Illinois, California, Texas
 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:

This injured worker is a 49-year-old male who sustained an industrial injury on 6/16/04, relative to a high-speed motor vehicle accident. He sustained bilateral wrist fractures and low back injuries. Conservative treatment has included chiropractic, activity modification, and medications. The 12/06/14 lumbar spine MRI impression documented L4/5 posterior annular tear in the intervertebral disc with 2-3 mm broad-based posterior disc protrusion resulting in bilateral neuroforaminal narrowing and canal stenosis, bilateral exiting nerve root compression, and facet joint hypertrophy. At L5/S1, there was bilateral neuroforaminal narrowing and canal stenosis secondary to an 8 mm broad-based posterior disc protrusion with facet hypertrophy and bilateral exiting nerve root compromise. The 6/8/15 lumbar spine x-ray findings documented mild loss of disc height at L4/5 and L5/S1, more pronounced at L5/S1. There were small anterior osteophytes at multiple levels and mild facet arthropathy at L4/5 and L5/S1. The 6/10/15 neurosurgical consult report cited constant lumbosacral pain radiating into the right buttock, posterolateral thigh, shin, calf, and right foot, and occasional left leg pain in a similar distribution. He complained of frequent numbness, tingling, cramps, and spasms in the right leg that greatly limit activity. He reported right leg weakness and frequent buckling. Physical exam documented normal range of motion, negative straight leg raise, 5/5 lower extremity strength, 2+ and symmetrical deep tendon reflexes, normal toe/heel walk, and absent clonus and Hoffman. Imaging showed a broad-based disc herniation eccentric to the left at L4/5 causing moderate right and severe left lateral recess stenosis with compression of the bilateral L5 nerve roots. At L5/S1, there was a broad-based disc herniation with severe bilateral lateral recess stenosis and

marked compression of the bilateral S1 nerve roots, right greater than left. The neurosurgeon indicated that the injured worker had a 10-year history of severe back pain and sciatica with lower extremity symptoms in an L5 and S1 distribution. The treatment plan recommended laminectomy and complete discectomy at the L4/5 and L5/S1 levels with transforaminal lumbar interbody fusion given the need for bilateral significant facetectomies. The 6/18/15 psychiatry/neurology report cited lower back pain with occasional radiation to the left hip, posterior thigh, calf and foot. He was pending authorization for spinal surgery. Physical exam documented restricted lumbar range of motion, paralumbar tenderness and spasms, slow gait pattern favoring the right leg, and positive bilateral straight leg raise. Imaging was positive for a 7-8 mm disc protrusion at L4/5 and a 4 mm disc protrusion at L5/S1 with annular tear. The treatment plan re-requested right L4/5 discectomy per the 1/13/14 neurosurgical report. Authorization was requested for laminotomy and discectomy of right L4/5 and supplies for Ortho-Stim TENS unit. The 7/13/15 utilization review non-certified the request for laminotomy and discectomy of right L4/5 as there was no current clinical documentation supporting the request for surgical intervention. The request for supplies for the Ortho-Stim TENS unit was non-certified as there was no documentation to support the medical necessity of this request.

IMR ISSUES, DECISIONS AND RATIONALES

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

Laminotomy and discectomy, Right Lumbar, L4-L5: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic: Discectomy/Laminectomy.

Decision rationale: The California MTUS recommend surgical consideration when there is severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies (radiculopathy), preferably with accompanying objective signs of neural compromise. Guidelines require clear clinical, imaging and electrophysiologic evidence of a lesion that has been shown to benefit both in the short term and long term from surgical repair. The guidelines recommend that clinicians consider referral for psychological screening to improve surgical outcomes. The Official Disability Guidelines recommend criteria for lumbar discectomy that include symptoms/findings that confirm the presence of radiculopathy and correlate with clinical exam and imaging findings. Guideline criteria include evidence of nerve root compression, imaging findings of nerve root compression, lateral disc rupture, or lateral recess stenosis, and completion of comprehensive conservative treatment. Guideline criteria have not been fully met. This injured worker presents with chronic persistent low back pain radiating into the lower extremities. There is imaging evidence of nerve root compromise at both the L4/5 and L5/S1 levels with radicular symptoms documented in an L5 and S1 distribution. Detailed evidence of long term reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. However, there are no clinical exam findings of focal right-sided nerve root compression. Additionally, this request is based on a neurosurgical

consult over 18 months ago prior to updated imaging. A recent neurosurgical request in June 2015 indicated that significant decompression was required at both the L4/5 and L5/S1 levels. There is no compelling rationale to support the medical necessity of this single level request in light of updated imaging. Therefore, this request is not medically necessary.

Supplies for Orth-Stim TENS (transcutaneous electrical nerve stimulation) unit: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-121.

Decision rationale: The Ortho-Stim unit provides a combination of interferential current, neuromuscular electrical stimulation (NMES), and galvanic current. The California MTUS guidelines for transcutaneous electrotherapy do not recommend the use of NMES in the treatment of chronic pain. Galvanic stimulation is considered investigational for all indications. Guidelines suggest that interferential current is not recommended as an isolated intervention. Patient selection criteria is provided if interferential stimulation is to be used despite lack of guideline support and includes ineffective pain control due to diminished effectiveness of medications, intolerance of medications, history of substance abuse, post-operative pain limiting functional ability, and failure to respond to conservative measures. There is no documentation that an electrical stimulation unit is currently in use or providing any functional benefit. There is no compelling rationale to support the medical necessity of supplies for an electrical stimulation unit that is no fully guideline supported. Therefore, this request is not medically necessary.