

Case Number:	CM15-0169173		
Date Assigned:	09/09/2015	Date of Injury:	10/30/2014
Decision Date:	10/27/2015	UR Denial Date:	07/31/2015
Priority:	Standard	Application Received:	08/27/2015

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: California

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 56-year-old male with an industrial injury dated 10-30-2014. A review of the medical records indicates that the injured worker is undergoing treatment for lumbago, unspecified thoracic and lumbar neuritis, osteoarthritis unspecified, pain in joint hand, L5-S1 herniation, retrolisthesis grade I, facet hypert, foramen-narrow, radiculopathy of the right leg with motor sensory changes along L5-S1 dermatomes, L4-5 "DH2" bilateral L5 entroch, and right wrist mild degenerative. Treatment consisted of diagnostic studies, prescribed medications, and periodic follow up visits. In a progress note dated 07-14-2015, the injured worker reported low back pain and right wrist pain. The injured worker reported that the pain radiates down into bilateral thighs with constant numbness in left thigh. The injured worker rated a 7-8 out of 10. Objective findings (7-14-2015) revealed decreased lumbar range of motion with pain, positive straight leg raises with radiculopathy to L4 dermatome, decrease sensation on left at L5, and motor weakness on left L5. The treating physician prescribed services for L4-S1 invasive percutaneous discectomy, pre-op medical clearance lab work, post-op physical therapy 3 times a week for 4 weeks for the lumbar spine, Ultracet 37.5-325mg #60 and associated surgical service: Electromyography (EMG) & NCV of the bilateral lower extremities, now under review. Utilization Review determination on 07-31-2015, denied the request for L4-S1 invasive percutaneous discectomy, pre-op medical clearance lab work, post-op physical therapy 3 times a week for 4 weeks for the lumbar spine, Ultracet 37.5-325mg #60 and associated surgical service: Electromyography (EMG) & NCV of the bilateral lower extremities.

IMR ISSUES, DECISIONS AND RATIONALES

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

L4-S1 invasive percutaneous discectomy: 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 (ODG) Low back, Percutaneous discectomy.

Decision rationale: The CA MTUS/ACOEM Guidelines are silent on percutaneous discectomy. According to the ODG, percutaneous discectomy (PCD) is not recommended, since proof of its effectiveness has not been demonstrated. PCD is a "blind" procedure done under the direction of fluoroscopy. It involves placing an instrument into the center of the disc space, and either mechanically removing disc material or vaporizing it by use of a laser, to create a void so that extruded material can return to the center of the disc. Percutaneous lumbar discectomy procedures are rarely performed in the U.S., and no studies have demonstrated the procedure to be as effective as discectomy or microsurgical discectomy. As the guidelines do not recommend percutaneous discectomy, the request is not medically necessary.

Pre-op medical clearance lab work: 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-op physical therapy 3 times a week for 4 weeks for the lumbar spine: 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.

Ultracet 37.5/325mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use.

Decision rationale: According to the CA MTUS/Chronic Pain Medical Treatment Guidelines, page 80, opioids should be continued if the patient has returned to work and the patient has improved functioning and pain. Based upon the records reviewed there is insufficient evidence to support chronic use of narcotics. There is lack of demonstrated functional improvement, percentage of relief, demonstration of urine toxicology compliance or increase in activity from the exam note of 7/14/15. Therefore, the request is not medically.

EMG/NCV of the bilateral lower extremities: Upheld

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

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies.

Decision rationale: Per the CA MTUS/ACOEM Guidelines Low Back Complaints, page 303-304 regarding electrodiagnostic testing, it states electromyography (EMG), including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks. It further recommends against EMG and somatosensory evoked potentials (SEPs) in Table 12-7. Table 12-8 recommends against EMG for clinically obvious radiculopathy. In this particular patient, there is no indication of criteria for electrodiagnostic studies based upon physician documentation or physical examination findings. There is clear documentation of lumbar radiculopathy from the cited records and exam note from 7/14/15. Therefore, the request is not medically.