

Case Number:	CM15-0032218		
Date Assigned:	02/25/2015	Date of Injury:	03/30/2000
Decision Date:	04/23/2015	UR Denial Date:	01/22/2015
Priority:	Standard	Application Received:	02/20/2015

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: Oregon, California
 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:

The injured worker is a 51-year-old male who reported an injury on 03/30/2000. The injured worker was in the process of placing a door in position when the door fell on him, causing injury to the low back. The current diagnosis is lumbar postlaminectomy syndrome. The injured worker presented on 11/12/2014 for a neurosurgery consultation. It was noted that the injured worker was status post L5-S1 effusion on 07/17/2003 with hardware removal and re-exploration on 12/06/2004. The injured worker reported left low back pain radiating into the left lower extremity with associated numbness and tingling. The injured worker also reported urinary continence at times. The current medication regimen includes oxycodone, gabapentin, Methocarbamol, orphenadrine citrate, and hydrocodone/acetaminophen. Upon examination, there was 5/5 motor strength in the bilateral lower extremities, 2+ deep tendon reflexes, and intact sensation. Recommendations at that time included a removal of hardware at L5-S1 and a redo foraminotomy. There was no Request for Authorization form submitted for this review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left Redo Foraminotomy and Removal of Posterior Instrumentation: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 288, 305 and 306. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-306. Decision based on Non-MTUS Citation Official Disability Guidelines.

Decision rationale: The California MTUS/ACOEM Practice Guidelines state a referral for surgical consultation is indicated for patients who have severe and disabling lower extremity symptoms; activity limitations for more than 1 month; clear clinical, imaging, and electrophysiologic evidence of a lesion; and a failure of conservative treatment. The Official Disability Guidelines recommend a discectomy/laminectomy when there is objective evidence of radiculopathy upon examination. Imaging studies should reveal evidence of nerve root compression, lateral disc rupture, or lateral recess stenosis. Conservative treatment should include activity modification, drug therapy, and epidural steroid injection. There should also be evidence of a referral to physical therapy, manual therapy, or the completion of a psychological screening. In this case, the injured worker is status post lumbar fusion. There is no documentation of a recent exhaustion of conservative treatment prior to the request for an additional surgical procedure. There is objective evidence of lumbar radiculopathy upon examination. There is no documentation of a significant functional limitation. The injured worker underwent electrodiagnostic studies on 10/06/2014, which revealed no evidence of neuropathy or radiculopathy. Given the above, the medical necessity has not been established in this case. As such, the request is not medically appropriate.

X-Ray of 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.