MAXIMUS Federal Services

Case Number:	CM15-0041699		
Date Assigned:	03/10/2015	Date of Injury:	04/25/2013
Decision Date:	05/01/2015	UR Denial Date:	02/19/2015
Priority:	Standard	Application Received:	03/05/2015

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 42-year-old male with a reported date of injury of 04/25/2013. The mechanism of injury was not stated. The current diagnoses include idiopathic low back pain, herniated nucleus pulposus, degenerative disc disease in the lumbar spine, lumbar spinal stenosis, spinal enthesopathy, sacrococcygeal spine syndrome, and pain dysfunction syndrome. The injured worker presented on 10/23/2014 with complaints of persistent low back pain. The injured worker reported associated numbness and weakness in the bilateral lower extremities. Previous conservative management has included rest and medication. The injured worker was utilizing Vicodin, baclofen, ibuprofen, and Tylenol with codeine. Upon examination of the lumbar spine, there was tenderness to palpation, muscle spasm, normal range of motion, positive straight leg raise, and an inability to perform Faber testing. There was 4/5 motor weakness in the bilateral lower extremities with sensory deficit on the left at L5-S1. Treatment recommendations at that time included a lumbar spine microdiscectomy, decompression, foraminotomy, and minimally invasive surgical approach at the bilateral L5-S1 levels. There was no Request for Authorization form submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar Spine Surgery of Microdiscectomy, Decompression Laminectomy, Foraminotomy in a minimally invasive surgical approach level bilateral left side, bilateral L4-5 and L5-S1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 305, 307.

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 (ODG) Low Back Chapter, Fusion (spinal).

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 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 or manual therapy. In this case, there was no documentation of an exhaustion of conservative management. There was also no evidence of a significant sensory or motor deficit upon examination in the specific L4-5 and L5-S1 dermatomal distributions. There were no official imaging studies provided for this review. Given the above, the request is not medically necessary.

Associated Surgical Service: 2-Day Inpatient Stay: 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.