MAXIMUS Federal Services

Case Number:	CM15-0083044		
Date Assigned:	05/05/2015	Date of Injury:	05/22/2013
Decision Date:	06/08/2015	UR Denial Date:	04/06/2015
Priority:	Standard	Application Received:	04/30/2015

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 York
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 38-year-old male who sustained an industrial injury on 5/22/2013. His diagnoses, and/or impressions, are noted to include: displacement of lumbar intervertebral disc without myelopathy; chronic musculoligamentous sprain/strain of the thoracolumbar spine; lumbar disc degenerative disc disease with protrusion, and with lumbosacral radiculopathy; thoracic or lumbosacral neuritis or radiculitis; sciatic neuritis; myofascitis, myalgia, and myospasm of the thoracolumbar and lumbosacral paravertebral musculature; and history of anxiety with depressed mood. No current imaging studies are noted. Electrodiagnostic studies, of the lumbosacral region, were stated to have been done on 4/7/2014. Functional back testing is noted to have been done on 9/3/2014. A panel qualified medical evaluation was noted to have been performed on 9/10/2014. His treatments have included epidural steroid injection therapy "and all conservative treatments"; medication management, with the addition of Colace; and rest from work. The progress notes of 7/16/2014 noted constant, severe lower back pain that radiated into the bilateral lower extremities, causing numbness, difficulty sleeping, and constipation which causes abdominal pain and makes bowel movements difficult. Objective findings noted a guarded gait, tenderness in the lumbar spine, bilateral lower extremity weakness, an absent right Achilles reflex, and decreased sensation in the right leg. The physician's requests for treatments were noted to include lumbar sacral micro-decompression surgery.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar sacral microdecompression at L4-L5: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 306.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-6.

Decision rationale: The California MTUS guidelines recommend surgery when the patient has had severe persistent, debilitating lower extremity complaints referable to a specific nerve root or spinal cord level corroborated by clear imaging, clinical examination and electrophysiological studies. MRI scan showed a change greater on the left side than the right where the patient's complaints were. Imaging did not corroborate with patient's clinical exam. The guidelines note the patient would have failed a trial of conservative therapy. The guidelines note the surgical repair proposed for the lesion must have evidence of efficacy both in the short and long term. The requested treatment: Lumbar sacral microdecompression at L4-L5 is NOT Medically necessary and appropriate.

Length of 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.