

Case Number:	CM14-0210425		
Date Assigned:	02/03/2015	Date of Injury:	04/10/2012
Decision Date:	03/04/2015	UR Denial Date:	11/17/2014
Priority:	Standard	Application Received:	12/15/2014

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, Sports Medicine

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 53-year-old male who reported an injury on 04/10/2012. The mechanism of injury occurred while bending down to pick up a box. His diagnoses include lumbar stenosis with right lower extremity radiculopathy. His past treatments have included physical therapy, epidural steroid injections, medications, and trigger point injections. Diagnostic studies have included x-rays and magnetic resonance imagings, of the cervical and lumbar spine. His surgical history was noncontributory. The injured worker presented on 10/22/2014, with radiating low back pain down to his bilateral legs. He rated the pain an 8/10 to 9/10. Upon physical examination of the lumbar spine, there was tenderness to palpation in the paraspinal musculature of the thoracic and lumbar regions. He was positive for muscle spasm in the lumbar region to the right. Range of motion upon flexion was at 40 degrees, extension was at 20 degrees, rotation to the right was at 40 degrees, left rotation was at 40 degrees, right tilt was at 30 degrees, and left tilt was at 30 degrees. Sensory testing with a pin wheel was normal. Motor examination by manual muscle test was normal. Deep tendon reflexes were 2/2 bilaterally. Circulation in the bilateral lower extremities were normal. The injured worker had a negative straight leg raise test bilaterally, and a negative Waddell's sign. Heightened pain response was not present. There was no significant change in the injured worker's physical examination compared to last visit. His current medications included ibuprofen, tramadol, and cyclobenzaprine. The treatment plan included a request for right sided L4-5 and L5-S1 discectomy and decompression, and subsequent durable medical equipment. The rationale for the request was that since the injured worker has radiculopathy with neurological impingement,

he would need surgery and postoperative durable medical equipment. The Request for Authorization form dated 10/22/2014 were provided within the documentation submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right-sided L4-L5 and L5-S1 discectomy and decompression: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307.

Decision rationale: The Request for right sided L4-5 and L5-S1 discectomy and decompression is not medically necessary. The injured worker has radiating low back pain. The CA MTUS/ACOEM guidelines recommend lumbosacral nerve root decompression in injured workers with severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies, preferably with accompanying objective signs of neural compromise. Additionally, the guidelines state that there must be activity limitation due to radiating leg pain for more than 1 month or extreme progression of lower leg symptoms, clear clinical imaging and electrophysiologic evidence of a lesion that has been shown to benefit in both the short and long term from surgical repair, and failure of conservative treatment to resolve disabling radicular symptoms. Furthermore, the guidelines state that before referral for a surgery, clinicians should consider referral for a psychological screening to improve surgical outcomes. The documentation submitted for review failed to provide electrophysiologic evidence of a lesion. Additionally, upon physical examination the injured worker's Waddell's sign was negative, sensation testing was normal. Additionally, the injured worker stated that all his medications were helping him, there was no indication that the injured worker had functional limitations due to radiating leg pain. Furthermore, there was no documentation submitted of a psychological screening. In the absence of the aforementioned documentation, the request for right sided L4-5 and L5-S1 discectomy and decompression is not medically necessary.

Post-operative evaluation by nurse after the first 24-hours the patient is at home or the day after: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Low Back, Home Health Services

Decision rationale: The request for postoperative evaluation by nurse after the first 24 hours the patient is at home or the day after is not medically necessary. The injured worker has radiating low back pain. The Official Disability Guidelines recommend home health services for patients

who are homebound, on a part time or intermittent basis. Medical treatment does not include homemaker services like shopping, cleaning, and laundry, and personal care hygiene given by home health aides like bathing, dressing, and using the bathroom, when this is the only care needed. The documentation submitted for review failed to provide evidence to meet the criteria for the request for the injured worker's requested service of a right sided L4-5 and L5-S1 discectomy and decompression. As the requested surgery is not medically necessary, the postoperative evaluation is not medically necessary. As such, the request for postoperative evaluation by nurse after the first 24 hours the patient is at home or the day after is not medically necessary.

One post-surgical back brace: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Low Back, Back brace, post operative

Decision rationale: The request for 1 postsurgical back brace is not medically necessary. The injured worker has radiating low back pain. The Official Disability Guidelines recommend a standard brace over a custom postop brace, if any, depending on the expertise and experience of the treating physician. The clinical documentation submitted for review failed to provide evidence to meet the criteria for a right sided L4-5 and L5-S1 discectomy and decompression. As the surgery did not meet medical necessity, the request for 1 postsurgical back brace is not medically necessary.

One post-surgical front-wheeled walker: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Knee, Walking Aids

Decision rationale: The request for 1 postsurgical front wheeled walker is not medically necessary. The injured worker has radiating low back pain. The Official Disability Guidelines state that frames or wheeled walkers are preferable for patients with bilateral disease. The documentation submitted for review failed to provide evidence that the patient has bilateral disabilities. Additionally, the clinical information submitted for review did not provide evidence to meet medical necessity for a right sided L4-5 and L5-S1 discectomy and decompression. Given the above, the request for 1 postsurgical front wheeled walker is not medically necessary.

Related surgical service: a two-day inpatient hospital stay: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Low Back, Hospital length of stay

Decision rationale: The request for related surgical service, a 2 day inpatient hospital stay, is not medically necessary. The injured worker has radiating low back pain. The Official Disability Guidelines recommend a 2 day inpatient hospital length of stay for a discectomy. The documentation submitted for review failed to meet the criteria for a right sided L4-5 and L5-S1 discectomy and decompression. The documentation submitted for review did not provide clinical evidence to meet the criteria for a right sided L4-5 and L5-S1 discectomy and decompression. As such, the request for related surgical service, a 2 day inpatient hospital stay, is not medically necessary.

Post-operative physical therapy for the lumbar spine, twice weekly for four weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 26.

Decision rationale: The request for postoperative physical therapy for the lumbar spine, twice weekly for 4 weeks, is not medically necessary. The injured worker has radiating low back pain. The California MTUS Postsurgical Treatment Guidelines recommend 16 postoperative visits over 8 weeks for discectomy and laminectomy surgeries. The documentation submitted for review failed to provide clinical documentation in order to meet the criteria for a right sided L4-5 and L5-S1 discectomy and decompression. Given the above, the request for postoperative physical therapy for the lumbar spine, twice weekly for 4 weeks, is not medically necessary.

Sprix nasal spray 75 mg, one count: 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 Pain, Sprix

Decision rationale: The request for Sprix nasal spray 75 mg, 1 count, is not medically necessary. The injured worker has radiating low back pain. The Official Disability Guidelines state that the total duration of use of this intranasal formulation, as well as other ketorolac formulations, should be for the shortest duration possible, and not exceed 5 days. The documentation submitted for review stated that the rationale for the request of Sprix nasal spray 75 mg, 1 count, was for postoperative use. As the documentation submitted for review failed to provide evidence to meet the criteria for the right sided L4-5 and L5-S1 discectomy and decompression, the request for Sprix nasal spray does not meet medical necessity. As such, the request for Sprix nasal spray 75 mg, 1 count, is not medically necessary.

Post-surgical re-evaluation in six weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Independent Medical Examinations and Consultations Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 7), page 127

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Pain, Office Visits

Decision rationale: The request for postsurgical re-evaluation in 6 weeks is not medically necessary. The injured worker has radiated low back pain. The Official Disability Guidelines recommend office visits to be medically necessary. Additionally, the guidelines state that the need for a clinical office visit with a healthcare provider is individualized and based upon a review of the patient's concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The documentation submitted for review failed to provide evidence to meet the criteria for a right sided L4-5 and L5-S1 discectomy and decompression. As the surgery does not meet medically necessary, the request for postsurgical re-evaluation does not meet medically necessary. As such, the request for postsurgical re-evaluation in 6 weeks is not medically necessary.