

Case Number:	CM14-0217863		
Date Assigned:	01/07/2015	Date of Injury:	12/14/2007
Decision Date:	03/18/2015	UR Denial Date:	12/10/2014
Priority:	Standard	Application Received:	12/29/2014

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: 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:

This injured worker is a 31 year old male who suffered a work related injury on 12/14/07 unloading a 132# drum with resultant shoulder and back pain. MRI of 10/31/2013 showed a right paracentral foraminal annular tear with L5-S1 protrusion with possible right lateral recess encroachment and mild impingement on the descending S1 nerve root. A protrusion at L4-5 with mild facet degenerative changes was noted. No significant extruded fragment was described.. EMGs and NCV's of 01/24/2014 showed a positive tibial H reflex which could either be distal tibial neuropathy or S1 radiculopathy. According to the PR2 note of 5/12/2014 he had back pain at 7/10 with worsening left leg pain. Exam showed his lumbar range of motion was normal with a positive left straight leg raising test. Chiropractic treatments were recommended. The visits of 6/12, 7/28 and 8/ 21/2014 were essentially unchanged. His visit of 9/11/24 recorded a normal range of motion of the lumbar spine, but his pain was rated at 8/10and his straight leg raising test was still positive. Per the physician notes from 10/23/14, he complains of low back pain with left lower extremity symptoms, rated at 7/10. He also complains of a decline in activity/function as a result of left lower extremity motor and sensory deficit. The treatment plan consists of a request for lumbar decompression, with associated inpatient stay, post-operative Norco, Anaprox, physical therapy, Tramadol, hydrocodone, and pantoprazole. Requests for authorization of chiropractor visits of 5/10, 6/12, and 7/28/14 were denied because no documented functional improvement was supplied. On 12/10/14 the Claims Administrator non-certified the surgery and associated services citing MTUS guidelines. The non-certified treatments were subsequently appealed for Independent Medical Review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydrocodone 7.5mg #120 (two month supply): Upheld

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

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-operative Norco 10/325mg #60: Upheld

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

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-operative Anaprox 560mg #60: Upheld

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

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 operative Keflex 550mg #28: Upheld

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

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.

Lumbar Spine Decompression with one day inpatient stay: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305. Decision based on Non-MTUS Citation Spinal fusion chapter-decompression

Decision rationale: Per ODG guidelines lumbar spine decompression is recommended for conditions of pinched nerves (Spinal fusion chapter) in selected patients. This worker does not have spinal stenosis with described ligament hypertrophy or facet hypertrophy and the MRI describes as possible right lateral recess encroachment with mild impingement on the S1 nerve root. The worker's complaint is on the left, not the right. According to the California MTUS guidelines surgery is considered only when serious spinal pathology or nerve root dysfunction is found. Documentation does not show such serious pathology. Surgery may be considered when there is severe disabling lower leg symptoms consistent with imaging studies and when there is clear clinical and imaging and electrophysiological evidence of a lesion that has been shown to benefit both in the short and long term from surgery. The findings are not consistent.

12 sessions of post-operative physical therapy for the lumbar spine: Upheld

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

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 operative Tramadol 50mg #60 for the lumbar spine: Upheld

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

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 operative Tramadol HCL ER 150mg #30 for the lumbar spine: Upheld

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

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.

Pantoprazole 20mg #60 with two refills: Upheld

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

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.