

Case Number:	CM15-0007105		
Date Assigned:	01/26/2015	Date of Injury:	05/02/2012
Decision Date:	03/26/2015	UR Denial Date:	01/07/2015
Priority:	Standard	Application Received:	01/13/2015

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: Texas

Certification(s)/Specialty: Orthopedic 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 55-year-old female who reported an injury on 05/02/2012. The mechanism of injury was not specifically stated. The current diagnoses include degenerative disc disease and osteoarthritis. The injured worker presented on 10/23/2014 with complaints of no changes in symptoms. The current medication regimen includes Aleve. Upon examination, there was decreased range of motion of the lumbar spine with pain, positive triggers, positive straight leg raise at 30 degrees and difficulty performing heel to toe walk. Recommendations at that time included an L5-S1 outpatient minimally invasive percutaneous discectomy. It was also noted that the injured worker underwent an MRI of the lumbar spine, on 02/25/2014, which revealed evidence of moderate right and moderate to severe left neural foraminal narrowing in conjunction with facet hypertrophy at L5-S1 secondary to a 2 mm posterior disc bulge with bilateral exiting nerve root compromise. The Request for Authorization form was submitted on 10/23/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

L4-S1 Minimally Invasive Percutaneous Discectomy: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment 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 (ODG) Low Back Chapter, Discectomy/Laminectomy.

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, manual therapy or the completion of a psychological screening. There was no documentation of radiculopathy in a specific dermatomal distribution. While there is evidence of nerve root compromise, there is no documentation of an exhaustion of all conservative treatments, to include active rehabilitation, drug therapy and epidural steroid injection. Given the above, the request is not medically appropriate at this time.

Associated Surgical Service: Medical Clearance and Labs: 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 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-Op Physical Therapy 3 Times A Week for 3 Weeks for The Low Back: 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.