

Case Number:	CM15-0110251		
Date Assigned:	06/22/2015	Date of Injury:	01/19/1999
Decision Date:	09/04/2015	UR Denial Date:	05/22/2015
Priority:	Standard	Application Received:	06/08/2015

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: California, Indiana, Oregon
 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 69 year old female who sustained an industrial injury on 01/19/1999. The injured worker was diagnosed with lumbar herniated nucleus pulposus with stenosis, spondylosis, bilateral sacroiliitis, and cervical and lumbar spine neuropathic pain. The injured worker is status post anterior cervical decompression and fusion (no date documented), L4 to the sacrum decompression and fusion (no date documented), bilateral shoulder arthroscopy in February 2014, left carpal tunnel and ulnar release in January 2013 and a right carpal tunnel release in May 2013. Treatment to date has included diagnostic testing with recent lumbar spine magnetic resonance imaging (MRI) on April 7, 2015 and electrodiagnostic studies on April 13, 2015, multiple surgeries, physical therapy, podiatry evaluation and treatment, lumbar epidural steroid injections, transforaminal epidural steroid injection at left L3-4, most recently on January 20, 2015 and medications. According to the primary treating physician's progress report on April 24, 2015, the injured worker continues to experience constant low back pain with radiation to the bilateral lower extremities and associated spasms, right side worse than left. The injured worker rates her pain level at 6/10 and is currently attending physical therapy once a week. Examination demonstrated tenderness and spasms immediately above the lumbar spine incision line, central and paralumbar areas. There was also positive sciatic notch tenderness. Positive straight leg raise, femoral stretch and tensions signs were noted bilaterally. Motor strength was decreased in the bilateral quadriceps. The injured worker was noted to have a stooped posture with significant claudication and ambulation difficulty. Current medications were not documented. Treatment plan consists of the current request for an interlaminar laminotomy and decompression at L3-L4,

internal medicine pre-operative clearance, assistant surgeon, inpatient one night hospital stay, transportation to and from the facility, home health evaluation, chronic pain management, Norco 10/325mg, post-operative lumbar brace, physical therapy for 24 sessions and front wheeled walker.

IMR ISSUES, DECISIONS AND RATIONALES

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

Interlaminar laminotomy and decompression at L3-L4: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) low back.

Decision rationale: CA MTUS/ACOEM Low back complaints, page 308-310 recommends surgical consideration for patients with persistent and severe sciatica and clinical evidence of nerve root compromise if symptoms persist after 4-6 weeks of conservative therapy. According to the ODG Low Back, discectomy/laminectomy criteria, discectomy is indicated for correlating distinct nerve root compromise with imaging studies. In this case the worker has claudication symptoms rather than radiculopathy. The MRI does not show severe stenosis which would account for these symptoms. The lateral recess stenosis and nerve root impingement is present but is not likely the cause of the symptoms. The request is not medically necessary.

Associated surgical service: assistant surgeon: 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

Associated surgical service: Internal medicine clearance before surgery: 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

Associated surgical service: inpatient hospitalization - one night: 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.

Post-op rehabilitative physical therapy - lumbar spine, 24 visits: 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 Official Disability Guidelines (ODG) low back.

Decision rationale: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Post op off-the-shelf lumbar brace: 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.

Post op front-wheeled walker: 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.

Associated surgical service: home health evaluation: 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.

Associated surgical service: transportation to and from facility: 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.

Norco 10/325 mg #60: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 80.

Decision rationale: According to the CA MTUS/Chronic Pain Medical Treatment Guidelines, page 80, opioids should be continued if the patient has returned to work and the patient has improved functioning and pain. Based upon the records reviewed there is insufficient evidence to support chronic use of narcotics. There is lack of demonstrated functional improvement, percentage of relief, demonstration of urine toxicology compliance or increase in activity from the exam note of 4/24/15. Therefore the request is not medically necessary.

Chronic pain management: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines medical management Page(s): 5.

Decision rationale: CA MTUS/ACOEM chronic pain management guidelines, medical management, page 5-7 states that a patient directed self-care model is the most realistic way to manage chronic pain. It is also stated that for long duration of intractable pain, referral to a multidiscipline program can be considered. In this case the duration and severity of symptoms are reasonable for referral to multidisciplinary pain management.