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| Case Number: | CM15-0120940 | | |
| Date Assigned: | 07/01/2015 | Date of Injury: | 02/04/2010 |
| Decision Date: | 07/31/2015 | UR Denial Date: | 06/03/2015 |
| Priority: | Standard | Application Received: | 06/23/2015 |

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 66 year old female, who sustained an industrial injury on 2/04/2010, due to cumulative trauma. The injured worker was diagnosed as having thoracic or lumbosacral neuritis or radiculitis, unspecified, spondylosis of unspecified site, without mention of myelopathy, and lumbago. Treatment to date has included diagnostics, acupuncture, lumbar epidural injections, and medications. On 4/23/2015, the injured worker presented for follow-up regarding her lumbar spine. Lumbar epidural steroid injection was denied. Lumbar range of motion was decreased and painful and straight leg raise test on the left was positive sitting and standing. The treatment plan included L2-3 and L4-5 minimally invasive discectomy and any repairs (outpatient), preoperative labs (urine), post-operative medication (Ultracet), and post-operative physical therapy at three times a week for three weeks, twelve sessions. Work status was modified. Magnetic resonance imaging of the lumbar spine (1/22/2015) was submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

L2-3, L4-5 minimally invasive discectomy and any repairs, outpatient: 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): 305-7.

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. Documents do not provide such evidence. 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: L2-3, L4-5 minimally invasive discectomy and any repairs, outpatient is NOT Medically necessary and appropriate.

Pre-op Labs UA: 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 medication: Ultracet 37.5/325mg one-two PO q4-6h #60: 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 physical therapy three times a week for three weeks twelve (sic) sessions: 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.