MAXIMUS Federal Services

Case Number:	CM15-0043642		
Date Assigned:	03/13/2015	Date of Injury:	10/28/2013
Decision Date:	06/01/2015	UR Denial Date:	02/17/2015
Priority:	Standard	Application Received:	03/09/2015

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 47-year-old male who sustained an industrial injury on October 28, 2013. He has been diagnosed with degenerative disc disease of the lumbar spine L4-L5 and L4-S1 with superimposed chronic myospasms. Treatment has included medication, physical therapy, chiropractic treatment, cream, and exercise. The injured worker presented on 03/16/2015 for a follow-up evaluation with complaints of persistent low back with radicular symptoms into the right lower extremity. Upon examination, there was a wide based gait, an inability to squat, limited lumbar range of motion with 37 degrees forward flexion, 15 degrees extension, 15 degrees right and left rotation, tenderness to palpation, paravertebral muscle spasm, normal motor strength with the exception of 4/5 on the left, and sensory loss over the dorsum of the right foot. Straight leg raise testing was positive at 90 degrees in the supine and sitting position on the right. Treatment recommendations included a lumbar decompression at L4-S1 on the right side. There was no Request for Authorization form submitted for this review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar Decompression L4-L5, L5-S1 on the Right Side: 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): 305-306. 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 lumbar discectomy/laminectomy when there is objective evidence of radiculopathy upon examination. Imaging studies should reveal nerve root compressions, 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 or manual therapy. In this case, it is noted that the injured worker has limited range of motion with 4/5 lower extremity weakness and sensory deficit over the dorsum of the right foot. However, there is no documentation of an exhaustion of conservative management to include epidural steroid injection. There is no evidence of a recent attempt at conservative treatment in the form of active rehabilitation. It was noted that the injured worker underwent an evaluation in 11/2014 where a possible epidural injection was recommended. Given the lack of an exhaustion of conservative treatment, the request cannot be determined as medically appropriate at this time.

One (1) Day Hospital Stay: 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.

Short Course of Postoperative Physical Therapy: 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.

Comprehensive Medical Clearance: 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.