

Case Number:	CM15-0062223		
Date Assigned:	04/08/2015	Date of Injury:	06/01/2014
Decision Date:	06/01/2015	UR Denial Date:	03/18/2015
Priority:	Standard	Application Received:	04/01/2015

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 33 year old male, who sustained an industrial injury on June 1, 2014. He reported injuring his back while dealing with a combative patient. The injured worker was diagnosed as having displacement of the lumbar intervertebral disc without myelopathy and herniated nucleus pulposus (HNP) with lumbar spine radiculopathy. Treatment to date has included x-rays, physical therapy, lumbar spine MRI, and medication. Currently, the injured worker complains of pain in the back with radiation to the left leg with numbness and tingling sensation in the leg, stress and anxiety, and sleep disorder. The Initial Treating Physician's report dated August 20, 2014, noted the physical examination of the cervical spine showed pain in the lower back with neck flexion. The Physician requested authorization for a lumbar spine epidural injections series of three, nerve root block, and physical therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar discectomy at L5-S1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints
Page(s): s 305-306.

Decision rationale: The request for a lumbar discectomy at L5-S1 is not medically necessary. According to the CA MTUS/ACOEM Guidelines, surgical intervention may be considered for patients who have documented evidence of severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies, preferably with accompanying objective signs of neural compromise, activity limitation due to radiating leg pain for more than 1 month, or extreme progression of lower leg symptoms; clear clinical, imaging, and electrophysiologic evidence of a lesion that has been shown to benefit in both the short and long term from surgical repair, and failure of conservative treatment to resolve disabling radicular symptoms. The documentation included an MRI of the lumbar spine, performed on 07/03/2014, which was noted to reveal at L5-S1, a central and left paramedian disc extrusion with caudal migration behind the superior body of L5. This was extending towards the left L5-S1 neural foramen. The disc extended 6 mm posteriorly into the spinal canal. The left L5 nerve root was normal. The left S1 nerve root appeared to be pushed posteriorly by the extruded disc fragment. The neural foramina were normal. Although the lumbar spine MRI revealed a disc extrusion centrally into the left at L5-S1, the documentation did not provide sufficient evidence of recent tried and failed conservative care. The patient complained of pain in the back, with radiation to the left leg, with associated numbness and tingling. However, upon physical examination, there were no significant objective neurological deficits noted. In the absence of documentation with sufficient evidence of recent tried and failed conservative treatment, the documented evidence of activity limitation due to radiating leg pain for more than 1 month, or severe and disabling lower leg symptoms in a distribution consistent with abnormalities on the imaging study, the request is not supported. As such, the request is not medically necessary.

Injection procedure for discography: 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.

Pre-operative 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.

Post-operative physical therapy for the lumbar spine, three times weekly: 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.

Consultation with a sleep specialist: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Independent Medical Examinations and Consultations Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 7), page 127.

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

Decision rationale: The request for consultation with a sleep specialist is not medically necessary. According to the Official Disability Guidelines, the need for a clinical office visit with a healthcare provider is individualized based upon a review of the patient's concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The determination of necessity for an office visit requires individualized case review and assessment, being ever mindful that the patient outcomes are achieved with eventual patient independence from the healthcare system through self care as clinically feasible. The submitted documentation did not provide sufficient evidence of patient concerns, signs and symptoms, or specific assessment of a sleep disorder. The rationale for the request was not clearly provided. Given the above, the request is not medically necessary.

Norco 10/325 mg: 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.