MAXIMUS Federal Services

Case Number:	CM15-0064191		
Date Assigned:	04/10/2015	Date of Injury:	04/30/2014
Decision Date:	05/18/2015	UR Denial Date:	03/26/2015
Priority:	Standard	Application Received:	04/03/2015

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: Illinois, California, 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:

This injured worker is a 63-year-old male who sustained an industrial injury on 4/30/14. Injury occurred when he hit a bump while riding in a school bus and working with an unruly student. Past medical history was positive for hypertension. Past surgical history was positive for left hip replacement. The 5/6/14 lumbar spine x-rays documented moderate degenerative changes at L1/2, L2/3, and L3/4. The 9/8/14 lumbar spine MRI impression documented 6 mm disc bulges with foraminal narrowing and facet hypertrophy at L3/4 and L4/5. At L1/2, there was a 4-5 mm disc bulge with left greater than right foraminal narrowing. At L2/3 and L5/S1, there was a 3-4 mm disc bulge with foraminal narrowing and facet hypertrophy. The 9/15/14 bilateral lower extremity EMG revealed active denervation potentials only in the left lumbar paraspinal muscles consistent with an active left lumbosacral radiculopathy. However, a specific nerve root level could not be stated due to lack of EMG findings in the lower extremity. Conservative treatment included medication, back support, medication, chiropractic treatment, and physical therapy without sustained improvement. The 11/21/14 pain management report cited lower back pain radiating to both lower extremity to the knees. Physical exam documented normal posture, gait, and heel/toe walking. Lumbar range of motion was limited in all planes with positive right straight leg raise. Sensation was diminished in the right L5 and S1 distribution. Strength and reflexes were intact. The treatment plan recommended acupuncture. The 2/6/15 treating physician report cited low back injury with decreased range of motion in all directions with positive trigger points. Heel walk was reported difficult. The diagnosis was L1-S1 disc herniations with foraminal narrowing, facet hypertrophy, and bilateral thoracic radiculopathy.

The treatment plan recommended L3-L5 epidural steroid injections. Authorization was requested on 3/13/15 for an outpatient L3-L5 minimally invasive percutaneous discectomy, a urinalysis and post-operative physical therapy x 9 sessions. The 3/26/15 utilization review non-certified the request for L3-L5 outpatient minimally invasive percutaneous discectomy and associated urinalysis and post-op physical therapy. The rationale for non-certification was based on no clear clinical imaging or electrodiagnostic evidence of radiculopathy or neural compromise and the absence of a neurologic exam.

IMR ISSUES, DECISIONS AND RATIONALES

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

L3-L5 Minimally Invasive Percutaneous Discectomy: 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): 306. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic: Mild- (minimally invasive lumbar decompression); Percutaneous diskectomy (PCD).

Decision rationale: The California MTUS guidelines do not recommend percutaneous endoscopic laser discectomy (PELD) and state these procedures should be regarded as experimental at this time. The Official Disability Guidelines state that minimally invasive lumbar decompression and percutaneous discectomy are not recommended, since proof of its effectiveness has not been demonstrated. Guidelines stated that percutaneous lumbar discectomy procedures are rarely performed in the U.S., and no studies have demonstrated the procedure to be as effective as discectomy or microsurgical discectomy. Guideline criteria have not been met. This injured worker has a history of low back pain radiating to both lower extremities to the knees. There is electrodiagnostic evidence for non-specific lumbosacral radiculopathy. There are limited clinical exam findings or imaging evidence of specific nerve root compression. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. Recent epidural steroid injections were requested with no documentation of response. There is no guideline support for this particular surgical procedure. Therefore, this request is not medically necessary.

Urine Analysis: 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 (9-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.