

<b>Case Number:</b>	CM13-0056376		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	10/26/2004
<b>Decision Date:</b>	03/24/2014	<b>UR Denial Date:</b>	11/05/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/22/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Orthopedic Surgery and is licensed to practice in California. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 patient is a 55-year old injured worker who was injured on 10/26/2004 while driving; a van pulled out and turned left in front of her. Medication history includes medications, Oxycodone 15 mg, Xanax 0.5 mg, Tramadol ER and NSAIDs. EMG/NCS of lower extremity dated 06/11/2013, revealed normal study of the bilateral lower extremities. Normal NCV of the peripheral nerves of the bilateral lower extremities. There were no electrodiagnostic findings to suggest the presence of a mononeuropathy, peripheral neuropathy, or lumbosacral plexopathy. MRI of the lumbar spine performed 08/12/2013 revealed: L3-L4 (2mm) broad based disc bulge. Lateral disc-osteophyte spurring, greater on the right; facet arthropathy and hypertrophy; mild to moderate bilateral foraminal stenosis, greater on the right. Mild narrowing of the central canal, increased since the previous examination. L4-L5 (2mm) retrolisthesis; Posterior annular tear; 3-4mm central disc protrusion impinging upon the anterior aspect of the thecal sac and extending laterally into the neural foramina that was greater on the right. Facet arthropathy, mild left and moderate right foraminal stenosis with impingement upon exiting nerve previous examination; L5-S1 "degenerative disc changes". Posterior annular tear; 3-4 mm broad based disc bulge increasing in size and extending laterally into both neural foramina. Facet arthropathy; bilateral foraminal stenosis, questionably increased since the previous examination. Lesser findings as described above. A clinic note dated 11/1/2013 documented the patient presented with complaints of 8/10 low back pain with lower extremity symptoms. She continued to complain of urology issues. Objective findings on exam included tenderness over lumbar spine. Lumbar range of motion with Flexion 50, extension 40, left and right lateral tilt 40, left rotation 50. Lower extremity neurologic evaluation unchanged. Positive straight left raise on right. Lower extremity examination on 10/02/2103 showed hypoesthesia in the L5-S1 distribution of the right lower extremity. The patient was diagnosed with right L4-5 and L5-S1 protrusion with

foraminal stenosis and radiculopathy. Treatment plan was right L4-5 and L5-S1 lumbar decompression.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Right L4-5 and L5-S1 lumbar decompression:** Upheld

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

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

**Decision rationale:** According to the California ACOEM Guidelines, surgical discectomy is recommended for carefully selected patients with nerve root compression due to lumbar disk prolapse provides faster relief from the acute attack than conservative management; but any positive or negative effects on the lifetime natural history of the underlying disk disease are still unclear. " In this case, there is documentation of abnormal clinical and imaging findings; however, there is lack of documentation of attempted and failure of prior trial of conservation care. The request for right L4-5 and L5-S1 lumbar decompression is not medically necessary and appropriate.

**Intrepid anesthesia ( [REDACTED] ): 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, three times a week for four weeks:** 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.

**Cold unit:** 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.

**Surgical assistant ( [REDACTED] ) 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.

**Inpatient 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.