

<b>Case Number:</b>	CM13-0068119		
<b>Date Assigned:</b>	05/16/2014	<b>Date of Injury:</b>	07/01/2008
<b>Decision Date:</b>	06/16/2014	<b>UR Denial Date:</b>	11/19/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/18/2013

### 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. The expert reviewer is Board Certified in Orthopedic Surgery, has a subspecialty in Hand 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 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/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 claimant is a 62-year-olds with a work related injury of 0701/08, resulting from lifting a heavy container, injuring his low back. MRI of the lumbar spine dated 08/28/13 identifies multilevel broad based disc osteophyte complexes, minimal retrolisthesis of L3 to L4, and moderate foraminal narrowing at multiple levels more prominent on the left at L4-5 and L5-S1. The electrodiagnostic study dated 08/22/13 did not reveal any evidence of lumbar radiculopathy. The claimant has been treated conservatively with medication management, injections, physical therapy, acupuncture, and a pain management referral. The plain film radiographs of 10/20/13 revealed no evidence of flexion or extension instability. A 10/28/13 progress report described continued complaints of low back pain with radiating leg pain and physical examination showed restricted lumbar range of motion, tenderness to palpation of the L4-5 and L5-S1 level, 5/5 motor strength, equal and symmetrical reflexes and no sensory deficits. Based on failed conservative care a multilevel L3 through S1 laminotomy, foraminotomy, and decompression was recommended.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**L3-S1 LAMINOTOMY, FORAMINOTOMY AND DECOMPRESSION OF NEURAL ELEMENTS:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 305-307.

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

**Decision rationale:** According to the MTUS/ACOEM Guidelines, regarding Lumbosacral Root Decompression, "Direct methods of nerve root decompression include laminotomy, standard diskectomy, and laminectomy. Chemonucleolysis with chymopapain is an example of an indirect method. Indirect chemical methods are less efficacious and have rare but serious complications (e.g., anaphylaxis, arachnoiditis). Percutaneous diskectomy is not recommended because proof of its effectiveness has not been demonstrated. Recent studies of chemonucleolysis have shown it to be more effective than placebo, and it is less invasive, but less effective, than surgical diskectomy; however, few providers are experienced in this procedure because it is not widely used anymore. Surgical diskectomy 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. Given the extremely low level of evidence available for artificial disk replacement or percutaneous endoscopic laser diskectomy (PELD), it is recommended that these procedures be regarded as experimental at this time." In this case, while the imaging study identifies stenosis, there is currently no indication of formal physical examination findings demonstrating a radicular process. The imaging report and electrodiagnostic studies fail to show any evidence of acute radiculopathy. A lack of clinical correlation between physical examination findings, imaging, and electrodiagnostic studies would currently fail to support the role of the multi-level laminotomy, foraminotomy and decompression being requested. Therefore, the request for L3-S1 laminotomy, foraminotomy and decompression of neural elements is not medically necessary and appropriate.

**INPATIENT 1-2 DAYS:** 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.

**ASSISTANT SURGEON:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American Association of Orthopaedic Surgeons Position Statement Reimbursement of The First Assistant at Surgery in Orthopaedic's.

**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-OP CLEARANCE (CONSULT, LABS, CXR AND EKG TEC): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (Low Back - Lumbar & Thoracic (Acute & Chronic Chapter); Acciaha 2007 Guidelines on Perioperative Cardiovascular Evaluation and Care for Noncardiac Surgery

**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.

**ICELESS COLD THERAPY UNIT WITH DVT AND LUMBAR WRAP: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee and Leg Chapter, Vesopneumatic Devices. Aetna Clinical Policy Bulletin: Cryoanalgesia And Therapeutic Cold.

**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.