

<b>Case Number:</b>	CM14-0008631		
<b>Date Assigned:</b>	02/12/2014	<b>Date of Injury:</b>	04/03/2008
<b>Decision Date:</b>	07/08/2014	<b>UR Denial Date:</b>	01/09/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/21/2014

### 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, 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 injured worker is a 40-year-old who reported an injury on April 3, 2008 after he opened a cell door which reportedly caused injury to his low back. The injured worker ultimately underwent micro decompressive surgery in March of 2010. The injured worker was conservatively treated postoperatively with physical therapy, medications, acupuncture, chiropractic care, and medial branch blocks. The injured worker underwent an MRI on October 14, 2011 that documented there was degenerative disc disease and facet arthropathy with retrolisthesis at the L3-4 and L5-S1 with a disc bulge displacing the left S1 nerve root. The injured worker underwent an electrodiagnostic study on April 18, 2013 that documented there were no abnormal findings. The injured worker was evaluated on December 16, 2013. It was documented that the injured worker had continued low back pain rated 7/10 to 10/10 that radiated into the left lower extremity. It was documented that the injured worker's persistent pain complaints had decreased his quality of life. Physical findings included limited lumbar range of motion secondary to pain. It was documented that the patient had no sensation deficits of the left lower extremity. The patient had 4+/5 of the tibialis anterior and extensor hallucis longus with inversion and eversion and a positive straight leg raising test bilaterally at 60 degrees. It was documented that the patient had an MRI dated December 4, 2013. However, this was not provided for review. A request was made for revision of microlumbar decompression at the L5-S1 with postoperative chiropractic care with 1 overnight stay. An appeal to the non-certification dated January 19, 2014 documented that the patient had a 4 mm retrolisthesis at the L5-S1 evidenced on the MRI from December 4, 2013 that produced persistent radicular findings recalcitrant to conservative measures and would benefit from surgical intervention.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**SPINE SURGERY REVISION, MICROLUMBAR DECOMPRESSION, AT LEFT L5-S1 WITH INPATIENT OVERNIGHT STAY AT THE SURGERY CENTER: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308-310.

**Decision rationale:** The requested spine surgery revision, microlumbar decompression at the left L5-S1 with inpatient overnight stay at the surgical center is not medically necessary or appropriate. The American College of Occupational and Environmental Medicine recommends lumbar decompression when there is evidence of significant decreases in function and radicular symptoms that are supported by diagnostic studies and have been recalcitrant to conservative treatments. The clinical documentation submitted for review does indicate that the patient has radicular symptoms that are recalcitrant to conservative treatment. However, the most updated MRI submitted for review was from 10/2011. The submitted documentation referenced an MRI from 12/04/2013 to support surgical intervention. This MRI was not submitted for review. Therefore, the need for surgical intervention cannot be determined. As such, the requested decompression for spine surgery revision, microlumbar decompression at left L5-S1 with inpatient overnight stay at the surgery center is non-certified.

**POST-OP PHYSICAL THERAPY 2 TIMES A WEEK FOR 6 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.

**POSTOP CHIROPRACTIC MANIPULATIONS 2 TIMES A WEEK FOR 6: 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.