

<b>Case Number:</b>	CM14-0171413		
<b>Date Assigned:</b>	10/23/2014	<b>Date of Injury:</b>	04/07/2003
<b>Decision Date:</b>	11/25/2014	<b>UR Denial Date:</b>	10/14/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/16/2014

### 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 Spine Surgeon and is licensed to practice in Texas. 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 55-year-old female who reported an injury on 04/07/2003. The mechanism of injury was not submitted for clinical review. The diagnoses included status post L3-4 corpectomy and ALIF, L3-S1 PSIF and bilateral laminotomies on 07/24/2013, status post L3-4 fusion, Pseudoarthrosis, L4-5 stenosis, bilateral lumbar radiculopathy, bilateral foot drop, L4-5 grade 1 spondylolisthesis. The previous treatments included physical therapy, medication, and cold therapy. The diagnostic testing included an Electromyography/Nerve Conduction Velocity (EMG/NCV), Computed Tomography (CT) of the lumbar spine, magnetic resonance imaging (MRI) of the lumbar spine dated 09/05/2014. Within the clinical note dated 09/30/2014, it was reported the injured worker complained of ongoing daily and constant lower back pain, which radiated down the buttock wrapping from the inner anterior thigh all the way around the posterior thigh. She rated her pain 7/10 to 8/10 in severity with medication and 10/10 in severity without medications. Upon the physical examination, the provider noted the injured worker had tenderness to palpation of the paravertebral muscles bilaterally. There was decreased sensation over the left L3-4 dermatome distribution. The injured worker had a positive straight leg raise at 60 degrees on the left. The MRI dated 09/05/2014 revealed extensive postoperative change pertaining to prior sequential multilevel laminectomies and prosthetic interbody fusion. There was mild facet arthropathy shown at the L5-S1 where there is less than 2 mm posterior disc bulging. Multilevel 2.5 mm to 3.5 mm posterior disc bulging/protrusion was shown at the intervening disc spaces between T11 and L3. The provider requested a left L3-4 laminotomy and L4 foraminotomy for continued L4 radiculopathy with evidence of significant arthropathy of the quadriceps that has failed to improve on conservative care including lifestyle modifications, medications, NSAIDs and physical therapy. The provider also requested an assistant surgeon;

inpatient hospital stay; preoperative medical clearance cervical collar, hard; and cervical collar, soft. The Request for Authorization form was submitted and dated 09/30/2014.

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

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

#### **Left L3-L4 Laminotomy: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-306. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Laminectomy/ laminotomy

**Decision rationale:** The request for Left L3-L4 laminotomy is not medically necessary. The California MTUS/ACOEM Guidelines note surgical considerations within the first 3 months after onset of acute back symptoms, surgeries are considered only when serious spinal pathology or nerve root dysfunction is not responsive to conservative therapy and obviously due to a herniated disc is detected. A disc herniation, characterized by protrusion of the central nucleus pulposus through a defect in the outer annulus fibrosis, may impinge on a nerve root, causing irritation, shoulder and arm symptoms and nerve root dysfunction. In addition, the Official Disability Guidelines, recommend laminotomy for lumbar spinal stenosis for patients with lumbar spinal stenosis, surgery is offered in a significant advantage over the nonsurgical treatment in terms of pain relief and functional improvement that was maintained after 2 year follow-ups. The imaging studies submitted failed to indicate the injured worker had evidence of foraminal or lateral stenosis. The efficacy of the injured worker's previous laminotomy was not submitted for clinical review. Therefore, the request for Left L3-L4 Laminotomy is not medically necessary.

#### **Left L4 Foraminotomy: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-306. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Foraminotomy.

**Decision rationale:** The request for Left L4 Foraminotomy is not medically necessary. The California MTUS/ACOEM Guidelines note surgical considerations within the first 3 months after onset of acute back symptoms, surgeries are considered only when serious spinal pathology or nerve root dysfunction is not responsive to conservative therapy and obviously due to a herniated disc is detected. A disc herniation, characterized by protrusion of the central nucleus pulposus through a defect in the outer annulus fibrosis, may impinge on a nerve root, causing irritation, shoulder and arm symptoms and nerve root dysfunction. In addition, the Official

Disability Guidelines note laminotomy is recommended for indications listed below. Surgical discectomy for carefully selected patients with radiculopathy due to lumbar disc prolapse provides faster relief from the acute attack than conservative management, although any positive or negative effects on the lifetime natural history of the underlying disc disease are still unclear. The clinical documentation submitted fails to indicate the injured worker to have severe unilateral quadriceps/anterior tibialis weakness or mild atrophy. The imaging study does not indicate the injured worker to have nerve root compression, lateral disc rupture, or lateral recess stenosis. Therefore, the request for a Left L4 Foraminotomy is not medically necessary.

**Assistant Surgeon:** 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 (xday):** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, 11th edition 2014, Low Back , "Laminectomy

**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 Medical Clearance:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, 12th Edition, 2014, Low back; regarding preoperative testing general

**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.

**Cervical Collar, Hard:** 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.

**Cervical Collar, Soft:** 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.