

<b>Case Number:</b>	CM14-0177157		
<b>Date Assigned:</b>	10/30/2014	<b>Date of Injury:</b>	03/26/2014
<b>Decision Date:</b>	12/17/2014	<b>UR Denial Date:</b>	10/08/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/27/2014

### 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 60-year-old male who reported an injury on 03/26/2014. The mechanism of injury was while he was in the process of loading human remains weighing 245 pounds he felt pain in his lower back. The diagnoses included lumbar radiculopathy, sequential disc fragment in lumbar spine and lumbosacral sprain. The previous treatments included medication; injections. Within the clinical note dated 09/18/2014, it was reported the injured worker complained of continued back and leg pain, right greater than left, despite lumbar epidural steroid injections. Physical examination revealed low back pain. The range of motion was noted to be flexion of 40 degrees, and extension of 10 degrees. There was paraspinal muscular tenderness to palpation. The provider noted a positive straight leg raise on the left and on the right. The provider requested a microdiscectomy surgery, preoperative chest x-ray, preoperative EKG, preoperative labs. However, a rationale was not submitted for clinical review. The Request for Authorization was submitted and dated 10/01/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Left L5-S1 microdiscectomy:** 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): 307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Discectomy/laminectomy

**Decision rationale:** The California MTUS/ACOEM Guidelines state surgical consideration is recommended when the injured worker is not responsive to conservative therapy obviously due to herniated disc.; severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging study; objective signs of neurocompromise; activity limitations due to radiating leg pain for more than 1 month of extreme progression of lower leg symptoms; clear, clinical, imaging and electrophysiological evidence of lesion that has been shown to benefit in both the short and long term from surgical repair and failure of conservative therapy. In addition, the Official Disability Guidelines state standard discectomy and microdiscectomy are of similar efficacy in the treatment of herniated disc. Criteria for surgery includes symptoms which confirm the presence of radiculopathy; objective findings on the examination need to be present; a straight leg raise test, cross straight leg raising and reflex exams should correlate with symptoms and imaging. L5 nerve root compression require 1 of the following, severe unilateral foot/toe/dorsiflexor weakness/mild atrophy, mild to moderate foot/toe/dorsiflexor weakness, unilateral hip/lateral thigh/knee pain. For S1 nerve root compression it requires severe unilateral foot/toe/plantar flexor/hamstring weakness/atrophy. Moderate unilateral foot/toe/plantar flexor/hamstring weakness and unilateral buttock/posterior thigh and calf pain. Imaging studies require 1 of the following for concordance between radicular findings and radiologic evaluation of physical examinations, nerve root compromise, lateral disc rupture, lateral recess stenosis. Conservative treatment including activity modification, medication, epidural steroid injections, physical therapy. The clinical documentation submitted indicated the injured worker to have positive exam findings of a positive straight leg raise. Additionally, there is indication the injured worker tried and failed on medication, and epidural steroid injections. However, there is lack of documentation indicating the injured worker had tried and failed on physical therapy. Additionally, there is lack of documentation submitted indicating imaging studies which corroborate the diagnosis warranting the medical necessity for the request. Therefore, the request is not medically necessary.

**Associated surgical service: Pre-op chest x-ray:** 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.

**Associated surgical service: Pre-op EKG:** 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.

**Associated surgical service: Pre-op labs:** 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.