

<b>Case Number:</b>	CM14-0182013		
<b>Date Assigned:</b>	11/06/2014	<b>Date of Injury:</b>	02/23/2003
<b>Decision Date:</b>	12/11/2014	<b>UR Denial Date:</b>	10/10/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/03/2014

### 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 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 45-year-old male who reported an injury on 02/23/2003 due to an unknown mechanism. Past treatments were medications, chiropractic treatment and physical therapy. Diagnoses were chest wall pain, low back pain, mid thoracic pain, neck pain status post right rotator cuff repair, status post thoracic and lumbar fusion, status post thoracotomy and tracheal repair and status post open reduction and internal fixation right femur fracture. Imaging studies of an MRI of the lumbar spine dated 03/03/2014 revealed L4-5 disc protrusion with disc protrusions and extrusions mainly L4-5 and L5-S1 with neuroforminal narrowing. No significant disc space narrowing seen. There was evidence of a prior hemilaminectomy defect on the left at L5-S1. The injured worker had L5-S1 microdiscectomy on the left in 2003. Physical examination dated 10/02/2014 revealed that the injured worker had an L5-S1 and L4-5 transforaminal epidural steroid injection and had only 3 days of pain relief. The injured worker was there to discuss possible surgical treatment options. Symptoms were reported to continue to involve the right side and the injured worker denied any significant low back pain or left lower extremity radicular pain. Examination revealed a positive straight leg raise on the right at 45 degrees, motor strength was 5/5, and no sensory deficits on examination. It was recommended that the injured worker have a microdiscectomy procedure. The Request for Authorization form was not submitted.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**1 day inpatient length of stay at [REDACTED] for right L4-5 microdiscectomy: Upheld**

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

**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, Discectomy/laminectomy, Hospital Length of Stay (LOS)

**Decision rationale:** The decision for 1 day inpatient length of stay at [REDACTED] for right L4-L5 microdiscectomy is not medically necessary. The American College of Occupational and Environmental Medicine state there should be severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies (radiculopathy), preferably with accompanying objective signs of neural compromise; activity limitations due to radiating leg pain for more than one month or extreme progression of lower leg symptoms. There should also be clear clinical, imaging, and electrophysiologic evidence of a lesion that has been shown to benefit in both the short and long term from surgical repair and failure of conservative treatment to resolve disabling radicular symptoms. The Official Disability Guidelines recommend the median length of stay (LOS) based on type of surgery. Discectomy is median 1 day; mean 2.1 days or best practice target (no complications) as outpatient. The Official Disability Guidelines criteria for discectomy/laminectomy are symptoms/findings which confirm presence of radiculopathy. Objective findings on examination need to be present. Straight leg raise test, crossed straight leg raising and reflex exams should correlate with symptoms and imaging. Imaging studies should include one of the following, for concordance between radicular findings on radiologic evaluation and physical exam findings: Nerve root compression (L3, L4, L5, or S1); Lateral disc rupture; or lateral recess stenosis. There should be documentation of conservative treatments, including all of the following: Activity modification (not bed rest) after patient education ( $\geq 2$  months); Drug therapy, requiring at least ONE of the following: NSAID drug therapy, other analgesic therapy, Muscle relaxants and Epidural Steroid Injection (ESI); Support provider referral, requiring at least ONE of the following (in order of priority): Physical therapy (teach home exercise/stretching), Manual therapy (chiropractor or massage therapist), Psychological screening that could affect surgical outcome, or Back school. The examination did not reveal any neurologic deficits for strength, sensation or reflexes. The imaging studies and examination do not correlate. Furthermore, the injured worker had physical therapy in May 2014 that indicated that stretches were helping. Given the above, the request for 1 day inpatient length of stay at [REDACTED] for right L4-L5 microdiscectomy is not medically necessary.

**Assistant surgeon: Upheld**

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

**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.

**H&P/EKG:** Upheld

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

**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.

**Preoperative labs (CBC, CMP, PT, PTT, UA):** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** As the requested surgical intervention is not supported by the documentation, the requested ancillary service is also not supported.

**Postoperative with [REDACTED]:** Upheld

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

**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.

**Preoperative with [REDACTED]:** Upheld

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

**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.