

<b>Case Number:</b>	CM14-0047921		
<b>Date Assigned:</b>	07/07/2014	<b>Date of Injury:</b>	01/21/2010
<b>Decision Date:</b>	08/13/2014	<b>UR Denial Date:</b>	04/11/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/16/2014

### 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 Surgeon, has a subspecialty in Spine Surgery 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 38-year-old male who reported an injury on 01/21/2010. The mechanism of injury was not stated. Current diagnoses include thoracic or lumbosacral neuritis or radiculitis and lumbar disc displacement. The injured worker was evaluated on 02/14/2014 with complaints of persistent lower back pain with radiation into the bilateral lower extremities. It is noted that the injured worker is status post epidural steroid injection without significant improvement. Physical examination revealed a well healed incision in the lumbar spine with positive paravertebral muscle spasm. Treatment recommendations at that time included an L3-4 lumbar discectomy with extension of the posterior fixation. It is noted that the injured worker underwent an magnetic resonance imaging (MRI) of the lumbar spine on 09/18/2013, which indicated a broad based disc protrusion at L3-4 measuring 6 mm in diameter located centrally in the left lateral recess extending to the foramen.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**L3-L4 Lumbar decompression laminectomy:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**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 Chapter, Discectomy/Laminectomy.

**Decision rationale:** California Medical Treatment Utilization Schedule (MTUS) American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Practice Guidelines state a referral for surgical consultation is indicated for patients who have severe and disabling lower extremity symptoms, activity limitation for more than 1 month, clear clinical, imaging, and electrophysiologic evidence of a lesion, and a failure of conservative treatment. The Official Disability Guidelines state prior to a discectomy/laminectomy, there should be evidence of radiculopathy upon physical examination. Imaging studies should reveal nerve root compression, lateral disc rupture, or lateral recess stenosis. Conservative treatments should include activity modification, drug therapy, and epidural steroid injections. There should also be evidence of the completion of physical therapy, manual therapy, or a psychological screening. As per the documentation submitted, there was no objective evidence of radiculopathy upon physical examination. There is no mention of an exhaustion of conservative treatment. Therefore, the injured worker does not meet criteria as outlined by the above mentioned guidelines for the requested procedure. As such, the request is not medically necessary and appropriate.

**Pre-op medical clearance and laboratory studies:** 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.

**Chest XR:** 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.

**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.