

<b>Case Number:</b>	CM14-0080813		
<b>Date Assigned:</b>	07/21/2014	<b>Date of Injury:</b>	03/30/2010
<b>Decision Date:</b>	09/19/2014	<b>UR Denial Date:</b>	05/13/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/02/2014

### 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 Occupational Medicine 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:

Medical records from 2013 to 2014 were reviewed. The patient complained of severe low back pain to the left midline radiating to the left buttocks, thigh and at times to the left ankle. Pain was rated 8/10. Left buttock pain radiates up to the left shoulder. Physical examination showed a slow gait; moderately restricted range of motion of the lumbar spine with pain in all planes; and tenderness over the midline lumbosacral spine. Neurological examination of the lower extremities showed decreased sensation in L4 dermatome; absent patellar tendon reflexes; and positive straight-leg raise at 40 degrees in the bilateral lower extremities. MRI of the lumbar spine done on February 18, 2011 revealed decrease in height and signal intensity of the L5-S1 disc with annular tear, and 3mm broad-based disc protrusion, greater on the right. The diagnoses were lumbar strain; degenerative disc L5-S1 with central disc protrusion and annular tear; and probable discogenic pain T11-T12. Left L5-S1 laminotomy and discectomy was recommended as well as an updated MRI of the lumbar spine prior to surgery. Treatment to date has included oral and topical analgesics, anxiolytics, lumbar ESI, and acupuncture. Utilization review from May 13, 2014 denied the request for left L5-S1 laminectomy and discectomy because there was no evidence of motor weakness, sensory deficit or reflex changes. Imaging studies identifying a focal lesion at left L5-S1 was lacking, and there was no documentation of adequate conservative treatment. The request for pre-op medical clearance and Vascutherm Cold Compression Unit (Post-op) were denied because the surgical request is not indicated. The request for MRI of the lumbar spine was denied as well due to absence of any progressive and new neurological deficit. Also, none of the prior MRIs were available for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Left L5-S1 Laminectomy and Discectomy: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) and the AMA Guides, pages 382-383 (Low Back Chapter).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Discectomy/Laminectomy.

**Decision rationale:** Pages 305 - 307 of CA MTUS ACOEM Guidelines state that lumbar surgical intervention is recommended for patients who have: severe lower leg symptoms in the distribution consistent with abnormalities on imaging studies, preferably with accompanying objective signs of neural compromise; activity limitations for more than one month; clear imaging of a lesion; and failure of conservative treatment to resolve disabling radicular symptoms. According to ODG, indications for discectomy/laminectomy require symptoms/findings; imaging studies; & conservative treatments. Symptoms/findings for L5 nerve root compression require one of the following: severe unilateral foot/toe/dorsiflexor weakness/mild atrophy, mild-to-moderate foot/toe/dorsiflexor weakness, or unilateral hip/lateral thigh/knee pain. Imaging studies require one of the following, for concordance between radicular findings on radiologic evaluation and physical exam finding: nerve root compression (L3, L4, L5, or S1), lateral disc rupture, or lateral recess stenosis. Conservative treatments requires all of the following: activity modification (not bed rest) after patient education ( $\geq$  2 months); drug therapy such as NSAID drug therapy, other analgesic therapy, muscle relaxants or epidural steroid injection (ESI); support provider referral such as physical therapy, manual therapy, or psychological screening that could affect surgical outcome. In this case, the above mentioned symptoms and imaging study findings were not found in the documents submitted. Objective findings for L5 nerve root compromise were also lacking. Moreover, there was no evidence that conservative treatment has failed to manage pain. The guideline criteria were not met. There was no clear indication for the request at this time. Therefore, the request for Left L5-S1 Laminectomy and Discectomy is not medically necessary.

**Pre Op 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 Guideline, Low Back Lumbar & Thoracic (Acute & Chronic) Chapter.

**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.

**MRI Lumbar: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guideline Low Back Chapter (ODG).

**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.

**Vascutherm Cold Compression Unit (Post Op):** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Knee & Leg Chapter (ODG).

**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.