

<b>Case Number:</b>	CM14-0155457		
<b>Date Assigned:</b>	09/25/2014	<b>Date of Injury:</b>	05/31/2008
<b>Decision Date:</b>	01/07/2015	<b>UR Denial Date:</b>	09/05/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/23/2014

### 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 Surgery and is licensed to practice in Minnesota. 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 54 year old male who experienced right shoulder and low back pain while carrying buckets of mixed cement up a ladder on 5/31/2008. The doctor's first report of occupational injury dated 8/18/2014 is a handwritten abbreviated form which is partly legible. The worker is experiencing pain in the right shoulder 6/10, back 7/10, and right leg 8/10, with tingling extremities. Exam revealed positive straight leg raising, decreased range of motion, and decreased sensation in the right L5 distribution. An agreed re-evaluation of July 23, 2013 indicates a history of low back and right leg pain radiating down the lateral aspect of the lower leg to the foot associated with numbness and tingling on the lateral aspect of right knee. Straight leg raising was positive in the seated and supine positions on the right. Sensation was diminished to light touch on the lateral aspect of the right lower leg. There was no motor weakness. The knee jerks were 2+ bilaterally and the Achilles' reflexes were 1+ bilaterally. A prior MRI scan of 11/17/11 had revealed a 1 cm annular tear and a broad based 4 mm posterior disc protrusion at L4-5 indenting the thecal sac, right more than left, with moderate central canal stenosis and mild neural foraminal stenosis. The Radiology report is not submitted. A prior EMG of 2011 had revealed a right L5 radiculopathy. No recent office notes or imaging studies are submitted. The disputed issues pertain to a request for facetectomy and foraminotomy at L5-S1 and fusion with iliac crest bone and instrumentation, and a lumbar decompression, laminectomy/ discectomy. The request was non-certified by UR because the level requested is L5-S1 and the notes refer to a disc protrusion at L4-5.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Facetectomy Foraminotomy at L5-S1 Fusion with Iliac Crest Bone: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305, 306, 307.

**Decision rationale:** The documentation submitted refers to a broad based protrusion at L4-5, right more than left, per MRI scan of 2011. There was evidence of a right L5 radiculopathy on the EMG at that time. The notes do not document a herniation at L5-S1. No recent imaging studies are submitted. The guidelines indicate surgical considerations when the abnormalities on the imaging studies are associated with severe disabling lower leg symptoms in a distribution consistent with the imaging studies. There should be a clear clinical and imaging evidence of a lesion that has been shown to benefit in both the short and long term from surgical repair. The MRI scan supports a protrusion at L4-5 and the surgery requested is at L5-S1. The request for a L5-S1 fusion, facetectomy, and foraminotomy is not supported by the documentation provided and is not medically necessary.

**Associated Surgical Service: Pre-Op Medical Clearance: 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.

**Associated Surgical Service: Electrocardiography (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: 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.

**Associated Surgical Service: Inpatient 2-3 Days:** 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: Intraoperative Monitoring Service, SSAP, Call Saver:** 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.

**Lumbar Decompression Including Laminectomy, Discectomy:** 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): 305, 306, 307.

**Decision rationale:** The facetectomy, foraminotomy, and spinal fusion with instrumentation is requested at the L5-S1 level. The available records refer to a protrusion at the L4-5 level and not at the L5-S1 level. Therefore the surgery as requested is not medically necessary. The request for

the lumbar decompression including laminectomy/ discectomy does not specify the level but given the request for the fusion, is not medically necessary.

**Associated Surgical Service: Graft and Instrumental Including Cage and Pedicle Screws:**  
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.