

<b>Case Number:</b>	CM15-0004073		
<b>Date Assigned:</b>	01/15/2015	<b>Date of Injury:</b>	03/06/2014
<b>Decision Date:</b>	04/17/2015	<b>UR Denial Date:</b>	12/18/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/08/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Pediatrics, Neurological Surgery

### 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 56-year-old male who reported an injury on 03/06/2015. The mechanism of injury involved a fall. The current diagnosis is thoracic/lumbosacral neuritis/radiculitis. The injured worker presented on 12/03/2014 for a consultation. The provider indicated that he had a lengthy discussion with the injured worker regarding imaging studies and symptoms. It was noted that the left lower extremity symptoms were consistent in the distribution of the posterior thigh and posterior lower leg, and when severe with standing or prolonged sitting, the injured worker also experienced symptoms in the anterior thigh on the left and below the knee on the anterior lower leg. The injured worker was able to tolerate and work full time with no activity restriction prior to the injury. Since the injury, the injured worker has had left lower extremity and left low back pain greater than right and 90% of his current symptoms are emanating from the left side. Upon physical examination, dorsiflexion was strong bilaterally at 5/5. Plain films were obtained in the office and did not demonstrate any abnormal segmental stability. There was no significant sagittal or coronal imbalance. Bilateral laminectomy at L3 through L5 with left L3-4, L4-5 and L5-S1 foraminotomy as well as left L4-5 far lateral discectomy was recommended. There was no Request for Authorization form submitted for this review. It was noted that the injured worker underwent an MRI of the lumbar spine on 11/10/2014, which revealed a stable L1 compression fracture, multilevel degenerative disc disease with central canal stenosis and neural foraminal narrowing.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Left L3-L4, L4-L5, L5-S1 Foraminotomies, Left L4-5 Lateral Discectomy: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): Surgical Considerations. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back - Indications for Surgery -Discectomy/laminectomy.

**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, Fusion (spinal).

**Decision rationale:** The California MTUS/ACOEM Practice Guidelines state a referral for surgical consultation is indicated for patients who have severe and disabling lower extremity symptoms; activity limitations for more than 1 month; clear clinical, imaging, and electrophysiologic evidence of a lesion; and a failure of conservative treatment. The Official Disability Guidelines recommend a lumbar discectomy/laminectomy when there is objective evidence of radiculopathy upon examination. Straight leg raising test, cross straight leg raising and reflex exams should correlate with symptoms and imaging. Imaging studies should reveal evidence of nerve root compression, lateral disc rupture or lateral recess stenosis. Conservative treatment should include activity modification, drug therapy, epidural steroid injection, physical therapy, or manual therapy. In this case, it is noted that the injured worker has subjective findings; however, there is no objective examination evidence of radiculopathy in a specific dermatomal distribution. Straight leg raising test, cross straight leg raising test and reflex examination does not correlate with symptoms or imaging. Given the above, the request is not medically appropriate at this time.

**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.

**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.

**Three (3) days hospital stay:** 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.

**Bilateral L3-L4, L4-L5, L5-S1 Laminectomies x 2:** 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.