

<b>Case Number:</b>	CM15-0161770		
<b>Date Assigned:</b>	08/27/2015	<b>Date of Injury:</b>	05/12/2014
<b>Decision Date:</b>	10/02/2015	<b>UR Denial Date:</b>	07/31/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/17/2015

### 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: Illinois, California, Texas  
 Certification(s)/Specialty: Orthopedic 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:

This injured worker is a 46-year-old male who sustained an industrial injury on 5/12/14. Injury occurred relative to a motor vehicle accident while employed as a bus driver. Past medical history was positive for diabetes, coronary artery disease, and hypertension. Conservative treatment included activity modification, pain medication, anti-inflammatory medication, physical therapy, and lumbar epidural steroid injection. The 7/19/14 lumbar spine MRI impression documented lumbar spine degenerative changes. At L4/5, disc height was preserved and there was a 2 mm broad-based posterior disc protrusion eccentric to the left and ligamentum flavum thickening measuring 3 mm in thickness bilaterally. There was no spinal canal, lateral recess or neuroforaminal narrowing noted. The facet joints were unremarkable. At L3/4, there was fissuring of the anterior portion of the annulus and end plate spurs projecting anteriorly. The right side of the ligamentum flavum was thickened. Records indicated that the injured worker underwent bilateral L5 and left L4 transforaminal epidural steroid injections on 3/30/15 with a 55% pain relief. The 7/20/15 spine surgery report cited grade 4-5/10 back pain radiating into the lower extremities, buttock, thigh and calf, mainly on the left side. His left leg intermittently gave out on him. Imaging showed a 2 mm broad-based disc bulge at L4/5, eccentric to the left with ligamentum flavum thickening and neuroforaminal narrowing on the left. Physical exam documented diffuse mid lumbar tenderness to palpation and positive straight leg raise on the left. Neurologic exam documented normal reflexes, 4/5 left dorsiflexion and plantar flexion weakness, and decreased sensation over the left lateral shin and anterior foot. The diagnosis included lumbar disc herniation with radiculopathy. The injured worker had failed two injections

and physical therapy. He had a left L5 radiculopathy and left sided L4/5 disc herniation with foraminal narrowing. Authorization was requested for left L4/5 discectomy with associated surgical requests for one day inpatient stay and physician assistant. The 7/31/15 utilization review non-certified the left L4/5 discectomy and associated surgical request as the clinical exam findings did not fully correlated with imaging findings. The 8/31/15 treating physician report cited intermittent low back pain occasionally radiating down the right buttocks and thigh and occasionally to the left leg. Symptoms were exacerbated by bending. He was taking anti-inflammatory medications and had lost 24 pounds. He was accommodated at work. Physical exam documented bilateral lower buttocks tenderness, tenderness from L2-L5, bilateral muscle spasms, and painful and restricted lumbar range of motion. Neurologic exam documented 4/5 left toe dorsiflexion, decreased left L4/5 dermatomal sensation, and diminished left patella and Achilles reflexes. Straight leg raise was positive. The diagnosis included thoracolumbar degenerative disc disease and lumbar radiculopathy. Surgical authorization was noted as pending.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Left L4-L5 discectomy:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Discectomy.

**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, Lumbar & Thoracic: Discectomy/Laminectomy.

**Decision rationale:** The California MTUS recommend surgical consideration when there is severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies (radiculopathy), preferably with accompanying objective signs of neural compromise. Guidelines require clear clinical, imaging and electrophysiologic evidence of a lesion that has been shown to benefit both in the short term and long term from surgical repair. The guidelines recommend that clinicians consider referral for psychological screening to improve surgical outcomes. The Official Disability Guidelines recommend criteria for lumbar discectomy that include symptoms/findings that confirm the presence of radiculopathy and correlate with clinical exam and imaging findings. Guideline criteria include evidence of nerve root compression, imaging findings of nerve root compression, lateral disc rupture, or lateral recess stenosis, and completion of comprehensive conservative treatment. Guideline criteria have been met. This injured worker presents with on-going and function-limiting back pain radiating into the lower extremities to the calf, especially on the left. Signs/symptoms and clinical exam findings are consistent with imaging evidence of plausible nerve root compromise. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. Therefore, this request is medically necessary.

**Associated surgical service: 1 day inpatient stay:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Hospital length of stay (LOS).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Lumbar & Thoracic: Hospital length of stay (LOS).

**Decision rationale:** The California MTUS does not provide hospital length of stay recommendations. The Official Disability Guidelines recommend the median length of stay (LOS) based on type of surgery, or best practice target LOS for cases with no complications. The recommended median length of stay for lumbar discectomy is 1 day and best practice target is outpatient. This request for one-day inpatient stay is consistent with the recommended median length of stay. Therefore, this request is medically necessary.

**Associated surgical service: Physician assistant:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Surgical assistant.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Centers for Medicare and Medicaid services, Physician Fee Schedule: Assistant Surgeons, <http://www.cms.gov/apps/physician-fee-schedule/overview.aspx>.

**Decision rationale:** The California MTUS guidelines do not address the appropriateness of assistant surgeons. The Center for Medicare and Medicaid Services (CMS) provide direction relative to the typical medical necessity of assistant surgeons. The Centers for Medicare & Medicaid Services (CMS) has revised the list of surgical procedures, which are eligible for assistant-at-surgery. The procedure codes with a 0 under the assistant surgeon heading imply that an assistant is not necessary; however, procedure codes with a 1 or 2 implies that an assistant is usually necessary. For this requested surgery, CPT code 63030, there is a 2 in the assistant surgeon column. Therefore, based on the stated guideline and the complexity of the procedure, this request is medically necessary.