Case Number:	CM15-0189579		
Date Assigned:	10/01/2015	**Date of Injury:**	10/20/2011
Decision Date:	11/10/2015	**UR Denial Date:**	08/26/2015
Priority:	Standard	**Application Received:**	09/25/2015

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 36-year-old male who sustained an industrial injury on 10/20/11. Injury occurred when the injured worker stepped over a piece of rebar and his pant leg got caught, causing him to fall down face first. Past medical history was positive for a subarachnoid hemorrhage, but it was not clear if this was related to this industrial injury, and hypertension. He underwent L4/5 disc replacement, L5/S1 anterior lumbar interbody fusion, L4-S1 posterior decompression and L5/S1 posterior non-instrumented fusion on 2/15/12. He underwent a re-exploration laminectomy at L5/S1 with resection and the medial lamina and partially fused facet, followed by scar dissection around the lateral recess, and microdiscectomy with decompression of the S1 nerve root on 4/29/14. A left foraminotomy at L5/S1 was performed on 4/29/15. The 7/2/15 lumbar spine MRI impression documented artificial disc replacement at the L4/5 level, and mild facet arthropathy. The injured worker was status post anterior discectomy and interbody fusion at the L5/S1 level and the facet joints may be partially fused at this level as well. There was disc desiccation and mild facet arthropathy at L1/2, L2/3, and L3/4. Findings documented mild facet arthropathy degenerative at the L4/5 with no obvious canal stenosis or neuroforaminal narrowing. The 7/2/15 CT scan impression documented artificial disc replacement at the L4/5 level. The hardware appeared to be in good position with no evidence of loosening. At the L5/S1 level, there was solid anterior bony fusion and the facet joints appeared to be at least partially fused bilaterally. There was mild facet arthropathy at all levels. The 7/23/15 treating physician report indicated that the injured worker had undergone a left L5/S1 foraminotomy for persistent left leg radiculopathy following his prior major reconstructive surgery. The left leg pain had completely resolved following surgery and post-operative therapy.

The injured worker had persistent right lower leg pain and tingling consistent with the L5 nerve root distribution following surgery. He had undergone an epidural steroid injection with a good but temporary response. Physical exam documented 3+ to 4/5 right ankle dorsiflexion with 4+/5 strength on the left. There was diminished right L5 dermatomal sensation. Deep tendon reflexes were symmetrical bilaterally at 2+. Active range of motion was reduced to 75% in flexion with pain radiating into the top of the right foot. Straight leg raise was on the right at 30 degrees. Imaging showed good fusion through L5/S1 and no issues with the artificial disc at L4/5. There was facet arthropathy at L4/5 bilaterally at the level of the artificial disc as well as lateral recess and foraminal stenosis. The diagnosis included symptomatic right L5 radiculopathy due to nerve root impingement at the right L4/5 lateral canal. A right L4/5 foraminotomy was recommended through a minimally invasive approach to relieve the mechanical compression of the nerve root at L4/5. Authorization was requested for right L4/5 foraminotomy and pre-operative medical work-up. The 8/28/15 utilization review non-certified the right L4/5 foraminotomy and pre-operative medical work up as there was no discrete imaging evidence of nerve root compression at the L4/5 level. There are well-defined objective physical findings commensurate with nerve root compression however there was no discussion as to why the current symptoms are not related to scar tissue and how repeated surgery was going to be successful in alleviating the symptoms. The 10/14/15 qualified medical examiner report documented review of the treating physician reports of 4/16/15 and 9/23/15, along with the lumbar spine MRI and CT scan. There were persistent and increasing subjective complaints consistent with right L5 radiculopathy due to nerve root impingement at the L4/5 level. The lumbar foraminotomy was felt to be reasonable.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right L4-L5 Foraminotomy: Overturned

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004.

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: 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 in both 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 persistent right leg pain and tingling in an L5 nerve root distribution. Symptoms are reported as increasing and function limiting. He had a

good but temporary response to an L4/5 epidural steroid injection. Clinical findings are consistent with plausible imaging evidence of nerve root compromise in the lateral recess at L4/5. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. Therefore, this request is medical necessity at this time.

Pre operative medical work up: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation www.quideline.gov/content.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Institute for Clinical Systems Improvement (ICSI), Preoperative evaluation, Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2010 Jun. 40 p.

Decision rationale: The California MTUS guidelines do not provide recommendations for pre-operative medical clearance. Evidence based medical guidelines indicate that a basic pre-operative assessment is required for all patients undergoing diagnostic or therapeutic procedures. Middle-aged females have known occult increased medical/cardiac risk factors. Guideline criteria have been met based on patient age, past medical history, and the risks of undergoing anesthesia. Therefore, this request is medically necessary.