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| <b>Case Number:</b>   | CM15-0205559 |                              |            |
| <b>Date Assigned:</b> | 10/22/2015   | <b>Date of Injury:</b>       | 04/12/2013 |
| <b>Decision Date:</b> | 12/08/2015   | <b>UR Denial Date:</b>       | 10/19/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 10/20/2015 |

### 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: New York, Montana, California  
 Certification(s)/Specialty: 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 51-year-old male with an industrial injury dated 04-12-2013. A review of the medical records indicates that the injured worker is undergoing treatment for lumbar radiculopathy. Medical records (07-07-2015) indicate ongoing low back pain with radiation to the left leg. According to the progress note dated 10-06-2015, the injured worker reported no improvements in his symptoms. Objective findings (05-05-2015, 07-07-2015, and 10-06-2015) revealed tenderness to palpitation over the lumbar paraspinal musculature, flexion 60 degrees, extension 25 degrees, and right and left bend 25 degrees. Diminished sensation over the left L3 and L4 dermatomes was also noted on exams. Magnetic Resonance Imaging (MRI) of the lumbar spine dated 02-20-2014 revealed L2-4 with posterior disc bulges resulting in moderate bilateral neural foraminal narrowing with bilateral exiting nerve root compromise. L4-L5 revealed posterior annular tear, and posterior disc bulge resulting in moderate bilateral neural foraminal narrowing with bilateral exiting nerve root compromise. L5-S1 revealed posterior disc bulge without evidence of canal stenosis or neural foraminal narrowing. Treatment has included diagnostic studies, prescribed medications, physical therapy, acupuncture, transcutaneous electrical nerve stimulation (TENS) unit, heating pad-cold unit, back support, epidural injection, and periodic follow up visits. The treatment plan included lumbar surgery and associated surgical services. The utilization review dated 10-19-2015, non-certified the request for Lumbar Laminectomy at L2-5, 3-day inpatient stay, Pre-op Clearance with MD and associated surgical service: History & Physical, EKG, Chest x-ray, Chem panel, CBC, PTT-INR, UA and post-operative physical therapy 2 times a week for 8 weeks.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Lumbar Laminectomy at L2-5: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Surgical Considerations.

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Surgical Considerations.

**Decision rationale:** The California MTUS guidelines do recommend lumbar surgery if there is clear clinical, electrophysiological and imaging evidence of specific nerve root or spinal cord level of impingement which would correlate with severe, persistent debilitating lower extremity pain unresponsive to conservative management. Documentation does not provide this evidence. Physical examination findings do not correlate with radiculopathy. Therefore, the requested treatment is not medically necessary and appropriate.

### **3 day inpatient 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.

### **Pre-op Clearance with MD: 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: History & Physical: 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: 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: Chest X-rays:** 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: Chem Panel:** 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: CBC:** 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: PTT/INR:** 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: UA:** 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.

**Post-op physical therapy 2 times a week for 8 weeks:** 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.