

<b>Case Number:</b>	CM15-0222763		
<b>Date Assigned:</b>	11/18/2015	<b>Date of Injury:</b>	12/08/2014
<b>Decision Date:</b>	12/30/2015	<b>UR Denial Date:</b>	10/28/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/12/2015

### 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 35 year old male-female, who sustained an industrial-work injury on 12-8-14. The injured worker was diagnosed as having lumbar spine sprain-strain with radicular complaints. Treatment to date has included medication, lumbar ESI (epidural steroid injection) (relief of 60% for 4 days relief only and then increased), 8 chiropractic sessions, and 8 physical therapy sessions. MRI results were reported on 1-13-15 of the lumbar spine revealed disc herniations at L5-S1 with prominent caudally extending extruded component, moderate right lateral recess stenosis with encroachment and displacement of the right S1 nerve root as discussed, minimal central canal and right neural foraminal stenosis is present. Currently, the injured worker complains of increased low back pain. Per the primary physician's progress report (PR-2) on 10-1-15, exam noted increased tone and tenderness about the paralumbar musculature with tenderness at the midline thoracolumbar junction and over the level of L5-S1 facets and right greater sciatic notch, muscle spasm, restricted range of motion, positive straight leg raise at 20 degrees on the right, and positive Lasegue's sign on the right. The Request for Authorization requested service to include L4-5 and L5-S1 microdiscectomy right sided and hemilaminectomy foraminotomy decompression, associated surgical service: assistant surgeon, 12 postoperative physical therapy sessions lumbar spine, and 12 postoperative cryotherapy treatments. The Utilization Review on 10-28-15 denied the request for L4-5 and L5-S1 microdiscectomy right sided and hemilaminectomy foraminotomy decompression, associated surgical service: assistant surgeon, 12 postoperative physical therapy sessions lumbar spine, and 12 postoperative cryotherapy treatments.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **L4-5 and L5-S1 microdiscectomy right sided and hemilaminectomy foraminotomy decompression: 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 recommend lumbar surgery when the patient has had severe persistent, debilitating lower extremity complaints referable to a specific nerve root or spinal cord level corroborated by clear imaging, clinical examination and electrophysiological studies. Documentation containing this supporting evidence is not found. The guidelines note the patient would have failed a trial of conservative therapy. The guidelines note the surgical repair proposed for the lesion must have evidence of efficacy both in the short and long term. The provider opines operating on the bulging disc at L4-5 is in the patient's best interests. Evidence that this disc is the cause of the patient's symptoms is not found. The requested treatment: L4-5 and L5-S1 microdiscectomy right sided and hemilaminectomy foraminotomy decompression is not medically necessary and appropriate.

**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: 12 post operative physical therapy sessions lumbar spine: 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: 12 postoperative cryotherapy treatments: 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.