

<b>Case Number:</b>	CM15-0030406		
<b>Date Assigned:</b>	02/24/2015	<b>Date of Injury:</b>	09/09/2012
<b>Decision Date:</b>	04/21/2015	<b>UR Denial Date:</b>	01/27/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/18/2015

### 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 52-year-old male who reported an injury on 09/09/2012. Prior therapies were noted to include lumbar epidural steroid injections on the right at L4-5 and L5-S1. The mechanism of injury was hard physical work and cumulative trauma. The injured worker was noted to keep missing therapy sessions. There was a Request for Authorization submitted for review dated 12/05/2014. The injured worker was noted to undergo electrodiagnostic studies on 09/11/2013, which revealed a possible cause of right L5-S1 radiculopathy versus peroneal neuropathy at the ankle. The injured worker underwent an MRI of the lumbar spine on 09/16/2013. The MRI revealed at the levels of L4-5 and L5-S1, there was a grade 1 anterolisthesis and canal stenosis that was mild to moderate at L4-5 and at L5-S1, it was moderate. The documentation of 12/05/2014 revealed the injured worker was in the office to discuss surgery. The injured worker had no significant changes since the last visit. The injured worker had a right epidural steroid injection on 11/25/2014, which provided 50% relief for 24 hours. The injured worker's treatment history was noted to include 8 sessions of chiropractic therapy and physical therapy, and bilateral transforaminal epidural steroid injections. The medications included LidoPro cream, ketoprofen cream, Terocin patches, tramadol ER, and Norflex with minimal to no relief. The current medications included Ultracet 37.5/325 mg 3 times a day and over the counter ibuprofen twice a day. The physical examination revealed diffuse tenderness to palpation in the lumbar spine. The range of motion was decreased. There was decreased sensation to light touch and pinprick in the right at the L4, L5, and S1 dermatomes. Motor strength was 4+/5 in the right TA, EHL, invertors, and evertors. The

straight leg raise was positive on the right at 80 degrees with pain in the mid-calf. The slump test was positive on the right and negative on the left. The diagnoses included lumbar spine HNP, lumbar radiculopathy, lumbar spine degenerative disc disease, and facet arthropathy. The treatment plan included a microlumbar decompressive surgery with a failure to improve on conservative care and injections as well as pain management follow-ups.

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

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

#### **Microlumbar Decompression Bilateral L4-L5, L5-S1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307.

**Decision rationale:** The American College of Occupational and Environmental Medicine indicates a surgical consultation may be appropriate for injured workers who have severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies preferably with accompanying objective signs of neural compromise. There should be documentation of activity limitations due to radiating leg pain for more than 1 month or the extreme progression of lower leg symptoms, and clear clinical, imaging and electrophysiologic evidence of a lesion that has been shown to benefit in both the short and long term from surgical repair and documentation of a failure of conservative treatment to resolve disabling radicular symptoms. The clinical documentation submitted for review indicated the injured worker had objective findings upon physical examination. The documentation additionally indicated the injured worker had trialed conservative care, including physical therapy and chiropractic care. The documentation, however, additionally indicated the injured worker had been unable to attend physical therapy sessions. Additionally, there was no official imaging or electrophysiologic imaging submitted for review. Given the above, the request for microlumbar decompression bilateral L4-5 quantity 1 is not medically necessary.

#### **Pre-operative Medical Clearance (included H&P) Qty 1.00: 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 services: EKG, Qty: 1: 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 services: Chest X-ray Qty 1.00:** 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 services: Lab- Chem Panel, CBC, APTT/PTT, Type and Screen, Qty 1.00:** 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 services: (UA) Urine Analysis Qty 1.00:** 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.