

<b>Case Number:</b>	CM15-0046030		
<b>Date Assigned:</b>	03/18/2015	<b>Date of Injury:</b>	09/10/2011
<b>Decision Date:</b>	05/11/2015	<b>UR Denial Date:</b>	03/04/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/11/2015

### 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: 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:

The injured worker is a 28 year old female, who sustained an industrial injury on 09/11/2011. She has reported subsequent low back and knee pain and was diagnosed with right L5-S1 disc herniation with right lower extremity radiculopathy and small right knee effusion. Treatment to date has included oral pain medication, epidural steroid injections and physical therapy. In a progress note dated 02/03/2015, the injured worker complained of continued back and leg pain with numbness and weakness. Objective findings were notable for diminished right heel walking, toe walking and heel to toe raising and right dorsolateral foot and calf numbness. The physician noted that the injured worker had failed conservative therapy and that lumbar laminectomy and discectomy would be requested.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Laminectomy L4-5, L5-S1:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); low back chapter, Indications for surgery.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints  
Page(s): s 305-306.

**Decision rationale:** The California MTUS/ACOEM Practice Guidelines state a referral for surgical consultation is indicated for patients who have severe and disabling lower extremity symptoms, activity limitations for more than 1 month, clear clinical, imaging, and electrophysiologic evidence of a lesion, and a failure of conservative treatment. The Official Disability Guidelines recommend a discectomy/laminectomy when there is objective evidence of radiculopathy upon examination. Imaging studies should reveal evidence of nerve root compression, lateral disc rupture, or lateral recess stenosis. Conservative treatment should include activity modification, drug therapy, and epidural steroid injection. There should also be evidence of a referral to physical or manual therapy. In this case, it was noted that the injured worker had exhausted conservative treatment. However, the extent of treatment was not documented. It is unclear whether the injured worker has completed any recent conservative management to include active rehabilitation or epidural steroid injection. In addition, there were no official imaging studies provided for this review. Given the above, the request is not medically appropriate at this time.

**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.

**Inpatient one day:** 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.

**Intraoperative neuromonitoring:** 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: lumbar back brace:** 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: Cold therapy unit-rental for 30 days:** 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.