

<b>Case Number:</b>	CM15-0052724		
<b>Date Assigned:</b>	03/26/2015	<b>Date of Injury:</b>	09/30/2013
<b>Decision Date:</b>	05/11/2015	<b>UR Denial Date:</b>	03/04/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/19/2015

### 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:

The injured worker is a 59-year-old male who sustained an industrial injury on 9/30/13. Injury occurred while working as a fire fighter involved in an auto extrication. The 7/31/14 lumbar spine MRI impression documented an interval left hemilaminectomy at L3/4 with relief of the previously described spinal stenosis. There was mild disc desiccation and disc space narrowing, 4 mm disc osteophyte complex, mild right neuroforaminal narrowing and mild to moderate left lateral recess and neuroforaminal narrowing. There was evidence of an L4/5 central disc protrusion with mild to moderate right lateral recess and neuroforaminal narrowing and an L5/S1 broad-based disc bulge with severe disc space narrowing, severe right degenerative changes, and mild left and moderate right neuroforaminal narrowing. The 3/2/15 treating physician report cited grade 7/10 low back pain radiating down the left leg in an L4 distribution with concurrent numbness and tingling and subjective weakness. Physical exam documented limited lumbar flexion/extension, 4/5 left iliopsoas and quadriceps strength, diminished sensation left lateral thigh to anterior knee, normal deep tendon reflexes, positive nerve tension signs, and antalgic gait. The treating physician report stated that the MRI clearly demonstrated evidence of a residual or recurrent left paracentral disc herniation causing significant lateral recess stenosis and impinging on the traversing L4 nerve root. The injured worker exhibits a clear left L4 radiculopathy in the distribution of pain and numbness and myotomal weakness. He had exhausted all continue non-operative treatment with continued pain, numbness and weakness. Authorization was requested for redo left L3/4 microdiscectomy. The 3/4/15 utilization review non-certified the request for revision left L3/4 microdiscectomy and associated pre-operative

testing based on conflicting documentation regarding pain distribution and neurologic exam findings and no imaging evidence of recurrent disc herniation.

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

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

#### **Revision of Left (Lumbar) L3-4 Microdiscectomy: Overturned**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 306. Decision based on Non-MTUS Citation Official Disability Guidelines: Indications for Surgery.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back i;½ 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 both in 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 function-limited low back and left lower extremity pain consistent with an L4 radiculopathy. Clinical exam findings are consistent with L4 radiculopathy and correlate with the treating physician report of imaging findings. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. Therefore, this request is medically necessary.

#### **Pre-operative Testing to include Labs (CBC complete blood count, BMP basic metabolic panel), EKG (electrocardiogram), Chest X-RAY: Overturned**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back - Lumbar & Thoracic (Acute & Chronic).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Practice advisory for preanesthesia evaluation: an updated report by the American Society of Anesthesiologists Task Force on Preanesthesia Evaluation. Anesthesiology 2012 Mar; 116(3):522-38.

**Decision rationale:** The California MTUS guidelines do not provide recommendations for this service. Evidence based medical guidelines indicate that a basic pre-operative assessment is required for all patients undergoing diagnostic or therapeutic procedures. Guidelines indicate that most laboratory tests are not necessary for routine procedures unless a specific indication is present. Indications for such testing should be documented and based on medical records, patient interview, physical examination, and type and invasiveness of the planned procedure. EKG may be indicated for patients with known cardiovascular risk factors or for patients with risk factors identified in the course of a pre-anesthesia evaluation. Routine pre-operative chest radiographs are not recommended except when acute cardiopulmonary disease is suspected on the basis of history and physical examination. Middle-aged males have known occult increased medical/cardiac risk factors. Guideline criteria have been met based on patient's age, the magnitude of surgical procedure, and the risks of undergoing anesthesia. Therefore, this request is medically necessary.