

<b>Case Number:</b>	CM15-0018407		
<b>Date Assigned:</b>	02/06/2015	<b>Date of Injury:</b>	09/15/2013
<b>Decision Date:</b>	05/26/2015	<b>UR Denial Date:</b>	12/31/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/30/2015

### 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: Oregon, 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 30-year-old male who reported an injury on 06/05/2013. The mechanism of injury involved repetitive lifting. The current diagnoses include L5-S1 disc herniation with stenosis, left lower extremity radiculopathy, L5-S1 facet arthropathy, status post L5-S1 discectomy, and L5-S1 left sided seroma with neural compression. The injured worker presented on 12/16/2014 for an orthopedic evaluation. The physician indicated the injured worker had not yet begun postoperative physical therapy. The injured worker was status post L5-S1 laminotomy, mesiofacetectomy, and microdiscectomy on 10/28/2014. The injured worker reported ongoing left sided low back pain radiating into the buttock region, causing numbness in the left anterior and posterior thigh. The pain was rated 7/10 to 9/10 on VAS. There was no comprehensive physical examination provided on that date. The physician indicated that he spoke with the radiologist, who identified moderate lateral recess stenosis on the left at L5-S1 with residual left S1 nerve root compression due to a small recurrent disc herniation. The physician indicated the injured worker could try a left L5 epidural steroid injection to minimize symptoms and avoid an additional surgery, but the likelihood that the injection would solve the problem was small. The injured worker did receive a prescription for a Medrol Dosepak postoperatively, which did not help to improve symptoms. Given the moderate lateral recess stenosis on the left at L5-S1 with residual left S1 nerve root compression, an additional surgery was recommended at that time. In addition, the physician recommended a postoperative LSO brace, pneumatic intermittent compression device, preoperative medical clearance with a chest x-ray, and a course of postoperative physical therapy 3 times per week for 6 weeks. The Request for Authorization

form was submitted on 12/16/2014. The official MRI of the lumbar spine report, completed on 12/15/2014, was submitted for review, and does indicate a small 2 to 3 mm left central to extraforaminal broad based disc protrusion at L5-S1 with moderate left and mild to moderate right sided narrowing, facet arthropathy, and ligamentum flavum redundancy.

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

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

#### **Left L5-S1 Microdiscectomy: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Microdiscectomy, Discectomy/Laminectomy.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-306. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Discectomy/Laminectomy.

**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 subjective evidence of radiculopathy upon examination. Imaging studies should reveal nerve root compression, lateral disc rupture, or lateral recess stenosis. Conservative treatment should include drug therapy, activity modification, and a referral to physical therapy or manual therapy. In this case, the injured worker is status post left L5-S1 microdiscectomy on 10/28/2014. In this case, there was no recent physical examination provided on the requesting date. There is no evidence of radiculopathy in the specific dermatomal and myotomal distribution. There is no indication that this injured worker underwent any type of postoperative treatment following the initial procedure. The physician indicated that the injured worker had not yet begun a course of postoperative physical therapy, although the procedure was 2 months prior on 10/28/2014. Given the above, the request for an additional procedure cannot be determined as medically appropriate at this time.

#### **Associated Surgical Service: LSO 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 Service: Pneumatic Compression Device: 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-Operative Physiotherapy (3 times a week for 6 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.

**Pre-Operative Medical Clearance:** 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-Operative Chest X-Ray:** 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.