

<b>Case Number:</b>	CM15-0110669		
<b>Date Assigned:</b>	06/17/2015	<b>Date of Injury:</b>	05/03/2014
<b>Decision Date:</b>	07/16/2015	<b>UR Denial Date:</b>	05/11/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/09/2015

### 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:

This injured worker is a 45-year-old male who sustained an industrial injury on 5/3/14. Injury occurred when he was stocking water and felt a pulling sensation in his back. Past medical history was positive for hypertension. The 8/11/14 electrodiagnostic study showed evidence of an acute bilateral L4, L5 and S1 lumbosacral radiculopathy. The 3/13/15 lumbar spine MRI showed extensive spondylosis of the lumbar spine with multilevel spinal canal and foraminal stenosis. At L3/4, there was 4-5 mm broad-based disc bulging with bilateral facet hypertrophy, moderate spinal canal stenosis with AP diameter reduced to 6-7 mm, and bilateral moderate foraminal stenosis. At L4/5, there was 4-5 mm broad-based disc bulge, bilateral facet hypertrophy and ligamentum flavum thickening, and moderate to severe spinal stenosis along with severe bilateral foraminal stenosis. At L5/S1, there was minimal central bulging, left lateral bulging up to 2 mm and mild left foraminal encroachment. The 4/2/15 treating physician report cited intermittent moderate lower back pain radiating to the left anterior and lateral thigh and right anterior and lower thigh. He had 18 sessions of physical therapy, 14 sessions of acupuncture, and 2 epidural injections with no long-term relief. Lumbar spine exam findings documented paralumbar muscle tenderness and spasms, decreased range of motion, positive left straight leg raise, and positive Lasegue's test on the left. There was decreased left L5 and S1 dermatomal sensation, absent bilateral Achilles reflexes, left 4-/5 iliopsoas, anterior tibialis, and peroneal weakness, and 3/5 left extensor hallucis longus weakness. Imaging showed extensive spondylosis of the lumbar spine with multilevel spinal canal and foraminal stenosis. The diagnosis included lumbar spine sprain/strain with radicular complaints, lumbar stenosis,

complete left foot drop, and bilateral knees sprain/strain. Authorization was requested for a left sided L5-S1 microdiscectomy with hemilaminotomy, foraminotomy, and decompression. An associated request was submitted by for postoperative cryotherapy. The 5/15/15 utilization review certified a request for L3/4 and L4/5 microdiscectomy on the right side and hemilaminotomy, foraminotomy, and decompression as there was evidence of advanced foraminal narrowing at L3/4 and L4/5 and the injured worker had failed conservative treatment. An associated request for post-op physical therapy 2 x 6 was certified. The request for left sided L5-S1 microdiscectomy with hemilaminotomy, foraminotomy, and decompression was non-certified as there was no imaging evidence of significant narrowing at the L5/S1 level. The associated request for post-operative cryotherapy 2 x 6 was non-certified as there was no indication that the injured worker was unable to tolerate home ice or cold packs.

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

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

**L5-S1 microdiscectomy left sided and hemilaminotomy foraminotomy decompression:**  
Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

**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 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 and function limiting low back pain radiating to the bilateral lower extremities. Clinical exam findings are consistent with electrodiagnostic evidence of L5/S1 radiculopathy and plausible imaging evidence of neural compression. 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.

**Post-operative cryotherapy 2 x 6 weeks:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints. Decision based on Non-MTUS Citation Harris J, Occupational Medicine Practice Guidelines, 2nd Editions (2004) - pages 367-377.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 299. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), Occupational Medical Practice Guidelines, Chapter 12 Low Back Disorders (Revised 2007), Hot and cold therapies, pages 160-161.

**Decision rationale:** The California MTUS are silent regarding cold therapy devices, but recommend at home applications of hot or cold packs. The ACOEM Revised Low Back Disorder Guidelines state that the routine use of high-tech devices for cold therapy is not recommended in the treatment of lower back pain. Guidelines support the at-home use of cold packs for patients with low back complaints. Guideline criteria have not been met. There is no compelling reason submitted to support the medical necessity of a cold therapy unit or in-office cryotherapy over the at-home use of cold packs in the absence of guideline support. Therefore, this request is not medically necessary.