

<b>Case Number:</b>	CM15-0113368		
<b>Date Assigned:</b>	06/19/2015	<b>Date of Injury:</b>	05/10/1994
<b>Decision Date:</b>	07/22/2015	<b>UR Denial Date:</b>	05/20/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/11/2015

### 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: New York

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 68 year old female, who sustained an industrial injury on 05/10/1994. She has reported injury to the low back. The diagnoses have included lumbar radiculitis; disorders of sacrum; and arthralgia sacroiliac joint. Treatment to date has included medications, diagnostics, epidural steroid injections, trigger point injection, pelvic traction, chiropractic therapy, physical therapy, and home exercises. Medications have included Tramadol, Nortriptyline, and Omeprazole. A progress report from the treating physician, dated 03/13/2015, documented an evaluation with the injured worker. The injured worker reported lumbar pain with radiation into the lower extremities to the top of the left foot, with tingling on the top of the left foot; pain is constant and rated at 4-5/10; numbness of the left lower extremity; difficulty sleeping on the left side; she has used pelvic traction which was helpful for flare-ups; chiropractic and physical therapy provided no longstanding relief; and Tramadol is used for pain. Objective findings included weakness at the left iliopsoas at 3/5 strength, left quad at 3plus/5 strength, posterior tibialis at 4/5 strength, and peroneal at 3/5 strength; decreased sensation to the left calf with sensory testing for pain; and decreased sensation left plantar foot with sensory testing for pain. Electrodiagnostic studies, dated 03/30/2015, were remarkable for mild, chronic radiculopathy, prominent evidence of chronic denervation/reinnervation; bilateral absence of all sensory responses in the feet, a common incidental finding in adults of this age group. The treatment plan has included the request for left L4-5, L5-S1 decompression; associated service: surgery assistant: associated service: post-op DME purchase: lumbosacral corset; and associated service: LOS: inpatient times one day.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Left L4-5, L5-S1 Decompression:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): s 305-7.

**Decision rationale:** The California MTUS guidelines recommend cervical surgery when the patient has had severe persistent, debilitating, upper extremity complaints referable to a specific nerve root or spinal cord level corroborated by clear imaging, clinical examination and electrophysiological studies. Documentation does not furnish this evidence. The guidelines note the patient would have failed a trial of conservative therapy. The guidelines note the surgical repair proposed for the lesion must have evidence of efficacy both in the short and long term. The requested treatment: Left L4-5, L5-S1 Decompression is not medically necessary and appropriate.

**Surgery assistant:** 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: Post-op DME purchase of a lumbosacral corset:** 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: 1 day inpatient stay:** 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.