

<b>Case Number:</b>	CM15-0174736		
<b>Date Assigned:</b>	09/25/2015	<b>Date of Injury:</b>	09/14/2014
<b>Decision Date:</b>	11/20/2015	<b>UR Denial Date:</b>	07/31/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/04/2015

### 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, Montana, 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 48 year old male, who sustained an industrial injury on September 14, 2014. He reported low back pain with pain radiating into bilateral lower extremities. The injured worker was diagnosed as having MLS lumbar strain, lumbar radiculitis, lumbar degenerative disc disease, lumbar facet arthropathy, myofascial pain syndrome and degenerative disc disease. Treatment to date has included diagnostic studies, lumbar selective nerve root block (SNRB) followed by lumbar epidural steroid injection (LESI) with mild relief, medications and work restrictions. Currently, the injured worker continues to report low back pain radiating to bilateral lower extremities with associated decreased range of motion of the lumbar spine and poor sleep. The injured worker reported an industrial injury in 2014, resulting in the above noted pain. Evaluation on March 4, 2015, revealed continued pain as noted. He rated his pain using a 1-10 visual analog scale (VAS) with 10 being the worst, at 8-9. He had noted tenderness overlying the lumbar paravertebral muscles and over the posterior superior iliac spine. Straight leg raise test was noted as positive. Lumbar spine flexion was noted at 50 degrees and extension at 10 degrees. It was noted he had a positive loading sign as well. Evaluation on March 14, 2015, revealed continued pain with associated radicular symptoms as noted. It was noted he was scheduled for bilateral lower extremity electrodiagnostic studies. Medications were continued and surgical intervention was discussed. Electrodiagnostic studies on May 28, 2015, revealed a normal study with possible mild radiculopathy on the right side and no definite motor lumbosacral radiculopathy on either side with no underlying peripheral neuropathy. Evaluation on June 5, 2015, revealed zero improvement with severe pain radiating down the bilateral legs. The RFA included requests for lumbar microdecompression of L1-L5, associated surgical services: CMP, EKG, PT, PTT, UA and chest x-ray and was modified on the utilization review (UR) on July 31, 2015.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Lumbar microdecompression L1-5: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back.

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Surgical Considerations.

**Decision rationale:** The California MTUS guidelines recommend lumbar surgery if there is severe persistent, debilitating lower extremity complaints, clear clinical and imaging evidence of a specific lesion corresponding to a nerve root or spinal cord level, corroborated by electrophysiological studies which is known to respond to surgical repair both in the near and long term. Documentation does not provide this evidence. EMG was normal and the MRI scan shows only mild changes L1-4. The requested treatment: Lumbar microdecompression L1-5 is not medically necessary and appropriate.

### **Associated surgical services: CMP: 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:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

### **Associated surgical services: PT/PTT: 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:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

### **Associated surgical services: UA: 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:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

**Associated surgical services: EKG:** 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:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

**Associated surgical services: 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:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.