

<b>Case Number:</b>	CM15-0064126		
<b>Date Assigned:</b>	04/10/2015	<b>Date of Injury:</b>	05/16/2011
<b>Decision Date:</b>	06/11/2015	<b>UR Denial Date:</b>	03/05/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/03/2015

### 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 34-year-old female who sustained an industrial injury on 5/16/11. Injury occurred when she was lifting a wood pallet resulting in back pain. The 8/5/11 lumbar spine MRI impression documented L5/S1 broad central disc protrusion eccentric to the right with mild thecal sac effacement and mild right subarticular recess effacement, possibly affected the right S1 nerve root. The 1/21/13 lumbar spine MRI conclusion documented slight progression of the previously described disc protrusion at L5/S1. Findings documented a slightly more focal contour of the L5/S1 central disc protrusion with less mass effect on the central and right paramedian thecal sac. The 2/26/15 treating physician report cited on-going low back pain radiating down the back of her left leg to the knee and pain in the left buttocks. Conservative treatment had included physical therapy, anti-inflammatory medications, and epidural steroid injection. Epidural steroid injection provided 50% pain reduction for 2 to 3 days. A discogram was reported positive for a painful disc at L5/S1. Physical exam documented lumbar range of motion with 40 degrees flexion and 0 degrees extension, and more pain with forward flexion. There as 4/5 left hamstring weakness, diminished bilateral Achilles reflexes, and decreased sensation over the left L4, L5, and S1 dermatomes. Straight leg raise was positive bilaterally. The diagnosis was large L5/S1 central home exercise program with left sciatica and weakness. Authorization was requested for microdiscectomy at L5/S1. The provider requested micro lumbar discectomy L5-S1, pre-op pre surgical staph aureus nasal swab and physician assistant assist. The 3/6/15 utilization review non-certified the request for L5/S1 microdiscectomy and associated pre-operative staph aureus nasal swab and surgical assistant. The rationale for non-

certification indicated that the most recent MRI was more than 2 years old, and updated imaging should be obtained prior to consideration of surgical intervention.

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

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

#### **Micro lumbar discectomy L5-S1: Overturned**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 305; 306.  
Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back Chapter.

**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<sub>6</sub><sup>1</sup>/<sub>2</sub> 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 low back and lower extremity pain. Physical exam documented motor and sensory deficits and reflex changes consistent with imaging evidence of nerve root compression at the L5/S1 level. 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-Op PreSurgical Staph Aureus Nasal Swab: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 305, 306.  
Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back Chapter.

**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. Guideline criteria have not been met. There is no compelling rationale presented to support the medical necessity of pre-operative staph aureus nasal swab for this injured worker. Therefore, this request is not medically necessary.

**Physician Assistant assist:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 305, 306. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back Chapter.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Centers for Medicare and Medicaid services, Physician Fee Schedule: Assistant Surgeons, <http://www.cms.gov/apps/physician-fee-schedule/overview.aspx>.

**Decision rationale:** The California MTUS guidelines do not address the appropriateness of assistant surgeons. The Center for Medicare and Medicaid Services (CMS) provide direction relative to the typical medical necessity of assistant surgeons. The Centers for Medicare & Medicaid Services (CMS) has revised the list of surgical procedures which are eligible for assistant-at-surgery. The procedure codes with a 0 under the assistant surgeon heading imply that an assistant is not necessary; however, procedure codes with a 1 or 2 implies that an assistant is usually necessary. For this requested surgery, CPT code 62287, there is a "1" in the assistant surgeon column. Therefore, based on the stated guideline and the complexity of the procedure, this request is medically necessary.