

<b>Case Number:</b>	CM15-0073877		
<b>Date Assigned:</b>	04/23/2015	<b>Date of Injury:</b>	09/24/2014
<b>Decision Date:</b>	05/21/2015	<b>UR Denial Date:</b>	03/19/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/17/2015

### 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: California

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:

The injured worker is a 50-year-old male who sustained an industrial injury on 9/24/14 involving his back, legs and thighs. He lifted approximately seventy five pounds and immediately felt onset of pain in his middle and lower back which was followed by pain, numbness and tingling radiating into his legs and thighs. He had x-rays, MRI, medications and physical therapy. He currently complains of low back tenderness with radiation to the left leg. His pain level is 5-7/10. Medications currently are Relafen, Tramadol, orphenadrine and diclofenac. Diagnosis is lumbar disc herniation with left leg radicular pain; lumbosacral strain/ sprain; thoracic sprain/ strain; bilateral thigh pain; abdominal pain; anxiety; depression and insomnia. Treatments to date include medications, therapies, epidural corticosteroids injections (2/24/15) without relief. Diagnostics include MRI lumbar spine (11/6/14) abnormal findings. MRI lumbar spine 11/6/14 demonstrates annular fissure at L3/4 and disc protrusion L4/5 causing mild canal and moderate bilateral lateral recess stenosis. In the progress note dated 3/6/15 the treating provider's plan of care recommends microlumbar discectomy. He has been symptomatic for more than six months and conservative treatments have not been success. Utilization Review also asks for pre-operative physical therapy twice a week for six weeks bilateral low back area.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Microdisectomy- Bilateral Low Back Area:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308-310.

**Decision rationale:** CA MTUS/ACOEM Low back complaints, page 308-310 recommends surgical consideration for patients with persistent and severe sciatica and clinical evidence of nerve root compromise if symptoms persist after 4-6 weeks of conservative therapy. According to the ODG Low Back, discectomy/laminectomy criteria, discectomy is indicated for correlating distinct nerve root compromise with imaging studies. In this patient, there is a persistent lumbar radiculopathy. The MRI from 11/16/14 demonstrates bilateral L4/5 lateral recess stenosis. Therefore, the guideline criteria have been met and determination is for certification. As a result, the request is medically necessary.

**Pre-operative Physical Therapy 2x 6x weeks, Bilateral Low Back area:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 25-26.

**Decision rationale:** CA MTUS/ACOEM is silent on the issue of preoperative clearance and testing. ODG, Low back, Preoperative testing general, is utilized. This chapter states that preoperative testing is guided by the patient's clinical history, comorbidities and physical examination findings. ODG states: These investigations can be helpful to stratify risk, direct anesthetic choices, and guide postoperative management, but often are obtained because of protocol rather than medical necessity. The decision to order preoperative tests should be guided by the patient's clinical history, comorbidities and physical examination findings. Patients with signs or symptoms of active cardiovascular disease should be evaluated with appropriate testing, regardless of their preoperative status. Electrocardiography is recommended for patients undergoing high risk surgery and those undergoing intermediate risk surgery who have additional risk factors. Patients undergoing low risk surgery do not require electrocardiography. Based on the information provided for review, there is no indication of any of these clinical scenarios present in this case. In this case the patient is a healthy 51 year old without comorbidities or physical examination findings concerning to warrant preoperative testing prior to the proposed surgical procedure. Therefore, the determination is for non-certification. With regards to postoperative PT, Per the CA MTUS/Post Surgical Treatment Guidelines, pages 25-26 recommend the following: Intervertebral disc disorders without myelopathy (ICD9 722.1; 722.2; 722.5; 722.6; 722.8): Postsurgical treatment (discectomy/laminectomy): 16 visits over 8 weeks; Postsurgical physical medicine treatment period: 6 months. Guidelines recommend 1/2 the visits be authorized initially. In this case, the 12 requested exceeds the 8 recommended. Therefore, the determination is for non-certification. As a result, the request is not medically necessary.

