

<b>Case Number:</b>	CM15-0074778		
<b>Date Assigned:</b>	04/24/2015	<b>Date of Injury:</b>	04/15/2013
<b>Decision Date:</b>	05/28/2015	<b>UR Denial Date:</b>	04/07/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/20/2015

### 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:

The injured worker is a 52-year-old female who sustained an industrial injury on 4/15/13. Injury occurred when she tripped over a carpet and fell on her knees. She was scapholunate left knee arthroscopy with meniscectomy. The 7/3/14 lumbar spine MRI impression documented multilevel disc desiccation. At L3/4, there was a 3 mm left paracentral/intraforaminal disc protrusion causing mild to moderate left neuroforaminal narrowing. At L4/5, there was a 3-4 mm broad-based disc bulge causing mild left and minimal right neuroforaminal narrowing, and hypertrophic degenerative changes were seen. At L5/S1, the disc was degenerated. There was a 2 mm central disc protrusion causing no significant neuroforaminal narrowing or canal stenosis. The 3/4/15 treating physician report cited continued pain in multiple body parts. She was using a cane to ambulation. She reported continued back pain radiating into the left lower extremity. MRI was reviewed and showed a 3-4 mm disc herniation at L4/5 and a 3 mm left disc herniation at the L3/4 level. The L5/S1 was relatively benign. The injured worker was complaining of left sided leg pain and some thigh pain most likely related to the L3/4 disc herniation. There was a loss of the patellar reflex on the left, and she is limping due to left sided leg pain. Epidural injections have been denied. Recent physiotherapy had been provided and symptoms did not improve. Surgery was recommended to include decompression at left L4/5 and L3/4. The 4/7/15 utilization review non-certified the request for lumbar micro-decompression left L3/4 and L4/5 as current findings did not clearly corroborate surgical lesions at L3/4 and L4/5 on the left. The 4/14/15 treating physician appeal letter stated that although the injured worker had a history of left knee pathology, the majority of the lower extremity complaints were due to her lumbar

internal derangement. She reported low back pain radiating into the left lower extremity with numbness and weakness. She had difficulty with bending, stooping, squatting and prolonged standing and walking. She ambulated with an antalgic gait. Physical exam documented lumbar paravertebral muscle spasms, tenderness, and guarding with decreased range of motion on flexion and extension. There was decreased sensation over the left L3, L4, and L5 dermatomes with pain. She had weakness with toe and heel walking, exhibited as 4/5 plantar flexion and dorsiflexion weakness. There was weakness with left knee flexion and extension. There was imaging evidence of 3 to 4 mm disc bulges at the L3/4 and L4/5 levels with mild foraminal stenosis at L4/5 and moderate left foraminal stenosis at L3/4. These findings were consistent with her complaints. She had over 6 months of conservative treatment in the form of medications, physical therapy, and lumbar injections, but remained symptomatic. The current decompression was felt to be sufficient to address her lower extremity symptoms and avoid arthrodesis.

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

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

#### **Lumbar Micro-Decompression of Left L3-L4, Left L4-L5: Overturned**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-328.

**MAXIMUS guideline:** Decision based on MTUS ACOEM 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 patient presents with persistent function-limiting low back pain radiating into the left lower extremity with numbness and weakness. Clinical exam findings were consistent with imaging evidence of plausible nerve root compression. Detailed evidence of at least 6 months 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 Medical Evaluation, with appropriate diagnostic and lab tests including Chest X-Ray:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-328.

**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; ACR Appropriateness Criteria® routine admission and preoperative chest radiography. Reston (VA): American College of Radiology (ACR); 2011. 6 p.

**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. Routine pre-operative chest radiographs are not recommended except when acute cardiopulmonary disease is suspected on the basis of history and physical examination. Although basic lab testing and a chest x-ray is typically supported for patients of similar age undergoing general anesthesia, the medical necessity of the non-specific lab testing requested could not be established. Therefore, this request is not medically necessary.