

Case Number:	CM13-0017735		
Date Assigned:	12/27/2013	Date of Injury:	05/31/2012
Decision Date:	03/05/2014	UR Denial Date:	08/02/2013
Priority:	Standard	Application Received:	08/28/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Spine surgery, and is licensed to practice in New York. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient is a 43 year old male with the date of injury of May 31, 2012. The patient has a diagnosis of lumbar disc herniation at L4-5 and L5-S1. Neurodiagnostic study indicates bilateral L4 radiculopathy not S1 radiculopathy. The patient has been treated with epidural injections and chiropractic therapy. He continues to complain of chronic low back pain. Patient had epidural L5-S1 steroid injection it reduces low back pain by 60% and leg pain by 80%. The patient continues to have pain radiating to his left leg. Physical examination the lumbar spine revealed reduced lumbar motion. Straight leg raising test is negative bilaterally. Sensation is reduced along the left L5 and left S1. The patient has had 3 epidural steroid injections with significant temporary relief. MRI lumbar spine dated August 15, 2012 shows mild congenital stenosis, degenerative changes, a 3 mm diffuse disc bulge at L4-5 that flattens the ventral aspect of the thecal sac, but no nerve root compression is identified. At L5-S1 as a 4 mm disc bulge that flattens the thecal sac and slightly abuts the descending S1 nerve roots bilaterally and may encroach upon descending left S1 nerve root. EMG shows evidence of bilateral L4 radiculopathy. The EMG findings and the MRI findings do not indicate specific radiculopathy that correlates with each other. At issue is whether L5-S1 microdiscectomy is medically needed.

IMR ISSUES, DECISIONS AND RATIONALES

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

Microdiscectomy L5-S1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 306.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: MTUS, page 305.

Decision rationale: This patient has not been established criteria for L5-S1 discectomy surgery. Specifically, the EMG findings show L4 involvement in the MRI shows slight abutment of the bilateral S1 nerve roots. The patient has a normal straight leg raising test bilaterally and does not have a physical exam that clearly documented S1 radiculopathy on the left side. Since the neurophysiologic testing does not demonstrate S1 radiculopathy, and the physical examination along with the MRI does not clearly correlate with the left S1 nerve root radiculopathy, criteria for left L5-S1 herniated disc surgery are not met.