

<b>Case Number:</b>	CM13-0025140		
<b>Date Assigned:</b>	12/11/2013	<b>Date of Injury:</b>	05/31/2012
<b>Decision Date:</b>	01/21/2014	<b>UR Denial Date:</b>	08/22/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/17/2013

### 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 Orthopaedic Surgery, has a subspecialty certificate in Fellowship trained in Spine Surgery, and is licensed to practice in California. 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 53-year-old male who reported an injury on 05/31/2012. He is reported to complain of ongoing low back pain. An MRI of the lumbar spine performed on 08/16/2012 read by [REDACTED], reported an impression of mild congenital spinal stenosis throughout the lumbar spine with mild decreased disc height, disc desiccation, anterolateral osteophytes, left-sided degenerative facet changes with a 3 mm diffuse disc bulge noted at the L4-5 level. The bulging disc flattens the ventral aspect of the thecal sac with no nerve compression noted. Disc desiccation, anterior osteophytes with a 4 mm diffuse disc bulge noted at the L5-S1 level. The bulging disc flattens the ventral aspect of the thecal sac and abuts the descending S1 nerve root bilaterally. It may in fact encroach upon the descending left S1 nerve root. An electrodiagnostic study performed on 12/04/2012 by [REDACTED] reported an impression of chronic bilateral L4 radiculopathy. On 03/15/2013, the patient was evaluated by [REDACTED] who reported the patient stated on 05/31/2012 after he finished emptying the trash cans, he started putting away the folding chairs and he suddenly felt a sharp pain in his lower back when he was lifting on the chairs. The patient is reported to have difficulty standing and walking properly due to his low back pain. The patient is reported to complain of lower back pain radiating to his legs which he reported between 2 to 4 in intensity with an aching and stabbing pain in his low back as well as aching pain in his left buttocks. He reported aching and numbness in his bilateral upper and lower legs and notes the symptoms in his lower back and leg worsen when walking and standing. He reported a feeling of weakness in his left leg and instability in both legs. On physical exam, the patient is noted to have mildly decreased range of motion of the lumbar spine in flexion and moderately decreased range of motion in extension. The patient is noted to have a positi

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Microdiscectomy at the level L5-S1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-306.

**Decision rationale:** The Physician Reviewer's decision rationale: The patient is a 53-year-old male who reported an injury to his low back on 05/31/2012 when he was performing repetitive lifting while performing his job duties. He is noted to have undergone an MRI on 08/15/2012 which noted disc desiccation, anterior osteophytes, and a 4 mm diffuse disc bulge at L5-S1 level which flattens the thecal sac and abuts the descending S1 nerve root and appears to encroach on the descending left S1 nerve root. The patient underwent an electrodiagnostic study on 12/04/2012 which reported findings of chronic bilateral L4 radiculopathy. The patient is noted to have treated conservatively with physical therapy, chiropractic therapy, and 3 epidural steroid injections which were reported to give him significant relief for 3 weeks. He is noted on physical examination to have reduced sensation in the left L4 and S1 dermatomes and mild restrictions of range of motion. California MTUS Guidelines recommend a lumbar decompression for patients with severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies with objective signs of neural compression after a failure of conservative treatment to resolve the disabling radicular symptoms. Before referral for surgery, clinician should consider a referral for psychological screening to improve surgical outcomes. Although the patient is reported to have findings of decreased sensation in the L4 and S1 distribution and is reported to have undergone an MRI which is reported to show a disc desiccation, anterior osteophytes, with a 4 mm disc bulge at the L5-S1 level that abuts the descending S1 nerve roots bilaterally and encroaches on the descending left S1 nerve root and on physical exam findings to have decreased sensation in the S1 dermatome and the L4 dermatome, the most recent imaging studies were approximately a year and a half old and there is no clinical imaging study or electrophysiological evidence of a lesion that is shown to benefit both in the short and long-term from the requested surgery. As such, the requested microdiscectomy at the L5-S1 level is non-certified.