

Case Number:	CM13-0038109		
Date Assigned:	12/18/2013	Date of Injury:	01/21/2004
Decision Date:	01/28/2014	UR Denial Date:	09/16/2013
Priority:	Standard	Application Received:	09/26/2013

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 Orthopedic 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:

This claimant is a 58-year-old male with a reported date of injury of 01/21/2004. The mechanism of injury is not specifically described by the records. He was taken to surgery for a left L5-S1 epidural steroid injection on 11/30/2011 and 05/01/2012. He had undergone 2 physical therapy visits as of 05/09/2012. An MRI dated 10/10/2012 revealed at L5-S1 there was disc desiccation with moderate loss of height and small right paracentral disc extrusion. It caused mild focal effacement of the right S1 nerve root but there was no compression of the thecal sac. He was seen in clinic on 10/23/2013 at which time lumbar spine range of motion was mildly decreased. Diagnoses included cervical spondylosis and foraminal stenosis with right upper extremity radiculopathy, lumbar spondylosis with referred pain to both lower extremities in a T10-11 right herniated disc with mid thoracic radiculopathy. The plan going forward was to recommend a microdiscectomy on the right at L5-S1.

IMR ISSUES, DECISIONS AND RATIONALES

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

Microdiscectomy on the right at L5-S1: Upheld

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

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

Decision rationale: This request is for an L5-S1 microdiscectomy to the right. The MRI of 10/10/2012 does indicate that he does have a small right paracentral disc extrusion causing mild focal effacement of the right S1 nerve root. There is no compression of the thecal sac at that level. The most recent clinical note dated 10/23/2013 fails to reveal any significant neurological deficits attributable to the lumbar spine or the lower extremities. There is no indication of motor deficits, sensory deficits, or reflex changes to the lower extremities. MTUS/ACOEM Guidelines indicate that there should be clear clinical imaging, electrophysiological evidence of a lesion that has been shown to benefit in both the short and long-term from surgical repair and there should be, "Failure of conservative treatment to resolve disabling radicular symptoms." While the records do indicate this claimant was seen in physical therapy, he was seen on 05/04/2012 and 05/09/2012 and underwent 2 physical therapy sessions. He did undergo 2 epidural steroid injections, 1 on 11/30/2011 and the second one on 05/01/2012. The most recent record fails to indicate that he has undergone significant conservative pharmacological management. The records are silent after 10/23/2013 and therefore the current status of this claimant is unknown. It is unknown whether he has radicular symptoms at this time or not. Therefore, due to a lack of documentation of significant current conservative measures in the form of physical therapy, lack of documentation of significant functional deficits on clinical exam, lack of documentation of electrodiagnostic studies, and lack of documentation of the current status of this claimant, this request is not considered medically necessary and is non-certified.