

<b>Case Number:</b>	CM14-0112785		
<b>Date Assigned:</b>	08/01/2014	<b>Date of Injury:</b>	02/12/2013
<b>Decision Date:</b>	09/10/2014	<b>UR Denial Date:</b>	06/18/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/19/2014

### 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. The expert reviewer is Board Certified in Neurological 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 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/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 injured worker is a 49-year-old male who reported an injury to his low back when he was lifting a piece of marble over his head resulting in low back pain on 02/12/13. The clinical note dated 05/20/14 indicates the injured worker having previously completed 6 sessions of physical therapy as well as an epidural steroid injection. The injured worker did report the injection did provide some benefit regarding the right leg complaints; however, the injured worker reported return to baseline levels of pain. The note also indicates the injured worker demonstrating strength deficits at the right extensor hallucis longus (EHL) rated as 4-/5. Range of motion deficits are identified in the lumbar region to include 60 degrees of flexion, 30 degrees of extension and 25 degrees of lateral rotation bilaterally. Reflex deficits are identified in the lower extremities. Diminished sensation was identified in the right L5-S1 distribution. The clinical note dated 07/08/14 indicates the injured worker continuing with low back and right leg pain. No significant changes are identified on physical examination. The clinical note dated 08/05/14 indicates the injured worker being recommended for a lumbar microdiscectomy and postoperative use of a lumbar support brace. The utilization review dated 06/19/14 resulted in a denial for the proposed operative procedure as no information had been submitted regarding the injured worker's imaging studies.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Outpatient right L5/S1 microdiscectomy:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307.

**Decision rationale:** The request for L5-S1 right sided microdiscectomy is not medically necessary. The documentation indicates the injured worker complaining of low back pain with associated sensation and strength deficits identified in the lower extremities. The clinical notes indicate the injured worker having completed six physical therapy sessions as well as an epidural steroid injection, all with no significant benefit. Therefore, the injured worker may benefit from the proposed surgical intervention. However, no imaging studies were submitted confirming the injured worker's significant pathology. Therefore, the request is not fully indicated as medically necessary.

**Lumbosacral support.:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Back Brace, Post-Operative (Fusion).

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.