

<b>Case Number:</b>	CM14-0095897		
<b>Date Assigned:</b>	07/25/2014	<b>Date of Injury:</b>	01/22/2013
<b>Decision Date:</b>	08/28/2014	<b>UR Denial Date:</b>	06/09/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/24/2014

### 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 Orthopedic Surgery and is licensed to practice in Texas. 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 59-year-old male who reported an injury on 01/22/2013. The mechanism of injury was not specifically stated. The current diagnoses include lumbar facet arthropathy, lumbar radiculitis, and lumbar sprain. The latest physician progress report submitted for this review is documented on 05/30/2014. The injured worker reported 8/10 pain. The current medication regimen includes nabumetone and nortriptyline. The physical examination revealed limited lumbar range of motion, tenderness to palpation, positive lumbar facet stress testing, 5/5 motor strength in the bilateral lower extremities, and intact sensation. Treatment recommendations at that time included a medial branch nerve block.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Left L5-S1 microdiscectomy:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines-TWC Low Back Procedure Summary.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): pp. 305-306. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Discectomy/Laminectomy.

**Decision rationale:** California MTUS ACOEM Practice Guidelines state a referral for surgical consultation is indicated for patients who have severe and disabling lower extremity symptoms; activity limitation for more than 1 month; clear clinical, imaging, and electrophysiologic evidence of a lesion; and a failure of conservative treatment. Official Disability Guidelines state prior to a discectomy, there should be objective evidence of radiculopathy. Imaging studies should reveal nerve root compression, lateral disc rupture, or lateral recess stenosis. Conservative treatment should include activity modification, drug therapy, and epidural steroid injection. As per the documentation submitted, there is no objective evidence of radiculopathy upon physical examination. There were also no imaging studies provided for this review. Based on the clinical information received, the request is not medically necessary and appropriate.