

Case Number:	CM15-0000158		
Date Assigned:	01/09/2015	Date of Injury:	10/20/2011
Decision Date:	03/17/2015	UR Denial Date:	12/23/2014
Priority:	Standard	Application Received:	12/31/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: Minnesota, Florida

Certification(s)/Specialty: Orthopedic Surgery

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

Injured worker is a 26 year old male who sustained an industrial accident on 10/20/2011, mechanism of injury was not documented. The injured worker has diagnoses of low back pain with pain radiating down the right leg with numbness and tingling. Utilization Review dated 12/23/2014 documents the Magnetic Resonance Imaging revealed 2-3 mm posterior central disc protrusion at L5-S1 without evidence of spinal stenosis and a 2 mm broad posterior disc protrusion at L4-L5 which indents the anterior thecal sac but does not result in significant stenosis or neuroforaminal narrowing. The injured worker states his low back symptoms have remain unchanged. In a physician note dated 12/15/2014 he was active and ambulatory without assistive aids. He has moderate pain in the lumbar are with moderate bilateral spasm. Treatment to date has included medications and physical therapy. The treating provider is requesting L4-S1 percutaneous minimally invasive diskectomy with repairs, and preoperative medical clearance. On 12/23/2014 Utilization Review non certified both requests citing California Medical Treatment Utilization Schedule (MTUS), American College of Occupational and Environmental Medicine (ACOEM), and Official disability Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

L4-S1 percutaneous minimally invasive diskectomy with repairs: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), percutaneous discectomy

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

Decision rationale: The injured worker has a history of low back pain. There is radicular pain in the right lower extremity associated with numbness and tingling per progress notes. Examination findings on 12/15/2014 indicated a height of 6 feet 0.5 inches and weight of 255 pounds with a BMI of 34.1. Gait was normal. There was no muscle atrophy. Neurologic examination of the lower extremities revealed normal sensation bilaterally. Knee jerks and Achilles reflexes were 2+ bilaterally. Motor strength in both lower extremities was equal and normal. Sitting straight leg raising was negative to 60 bilaterally and supine to 50. Range of motion of the lumbosacral spine was diminished with flexion 60, extension 10, right lateral flexion 10 and left lateral flexion 20, right rotation 30 and left rotation 30. The MRI scan of the lumbar spine revealed 2-3 mm posterior central disc protrusion at L5-S1 without evidence of spinal stenosis and a 2 mm broad posterior disc protrusion at L4-5 which indents the anterior thecal sac but does not result in significant stenosis or neural foraminal narrowing. The provider is requesting L4-S1 percutaneous minimally invasive discectomy with repairs. California MTUS guidelines indicate percutaneous discectomy is not recommended because proof of its effectiveness has not been demonstrated. The guidelines also indicate need for surgical considerations in severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies preferably with accompanying objective signs of neural compromise, activity limitations due to radiating leg pain for more than one month or extreme progression of lower leg symptoms, and clear clinical, imaging, and electrophysiologic evidence of a lesion that has been shown to benefit in both the short and long-term from surgical repair and failure of conservative treatment to resolve disabling radicular symptoms. The requested procedure of percutaneous discectomy is not supported by guidelines. Furthermore, there is no objective evidence of radiculopathy corroborating the imaging studies and there is no clear evidence of nerve root compression on the imaging studies.. Electrophysiologic studies have not been done. As such, the request for percutaneous discectomy at L4-S1 is not supported by guidelines and the medical necessity of the request is not substantiated.

Associated surgical service: Pre-operative medical clearance: Upheld

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

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

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

