

Case Number:	CM15-0144282		
Date Assigned:	08/05/2015	Date of Injury:	09/10/2012
Decision Date:	09/09/2015	UR Denial Date:	07/17/2015
Priority:	Standard	Application Received:	07/24/2015

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: Illinois, California, Texas
 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:

This injured worker is a 59-year-old male who sustained an industrial injury on 9/10/12. Injury occurred when he was electrocuted. The 10/28/14 lumbar spine MRI impression documented diffuse spondylotic change and endplate sclerotic changes. At L1/2, there was a 2 mm broad-based disc protrusion resulting in left neuroforaminal narrowing and left exiting nerve root compromise. At L2/3, there was a 2-3 mm broad-based posterior disc protrusion without evidence of canal stenosis or neuroforaminal narrowing. At L3/4 and L4/5, there were 3 mm broad-based posterior disc protrusions resulting in bilateral neuroforaminal narrowing. There was canal stenosis and bilateral exiting nerve root compromise at both levels. At L5/S1, there was facet hypertrophy resulting in bilateral neuroforaminal narrowing and bilateral exiting nerve root compromise. The 6/12/15 orthopedic report indicated that the injured worker was 3 months status post right rotator cuff repair with continued complaints of lower back pain radiating to his legs. Lumbar spine exam documented paraspinal tenderness to palpation, normal lumbar range of motion, and negative straight leg raise. Lower extremity neurologic exam documented 5/5 strength, 2+ and symmetrical deep tendon reflexes, and diminished sensation over the bilateral L4 dermatomes. The diagnosis included persistent lumbar radiculopathy. The injured worker had failed conservative treatment with anti-inflammatories, physical therapy, and epidural steroid injection. He had neurologic deficits concordant with imaging findings. Authorization was requested for L3-L5 percutaneous discectomy and post-operative physical therapy 2 times a week for 8 weeks. The 7/17/15 utilization review non-certified the L3-L5 percutaneous discectomy and post-op physical therapy as there was no indication of what specific conservative

treatment had been done and percutaneous discectomy was not recommended by guidelines as its effectiveness had not been demonstrated. The 7/24/15 treating physician report noted the denial of the percutaneous discectomy and requested appeal with a modified request for an L4 to S1 decompression and possible fusion if iatrogenic instability arises from the instability.

IMR ISSUES, DECISIONS AND RATIONALES

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

L3-L5 Percutaneous Discectomy: 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): 306. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back ? Lumbar & Thoracic: Percutaneous discectomy (PCD).

Decision rationale: The California MTUS guidelines do not recommend percutaneous endoscopic laser discectomy (PELD) and state these procedures should be regarded as experimental at this time. The Official Disability Guidelines state that minimally invasive lumbar decompression and percutaneous discectomy are not recommended, since proof of its effectiveness has not been demonstrated. Guidelines stated that percutaneous lumbar discectomy procedures are rarely performed in the U.S., and no studies have demonstrated the procedure to be as effective as discectomy or microsurgical discectomy. Guideline criteria have not been met. This injured worker presents with persistent low back pain radiating to his legs. Clinical exam findings evidenced a sensory deficit consistent with nerve root compromise at the L3/4 and L4/5. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. Additionally, there is no rationale provided to support the medical necessity of percutaneous discectomy over standard discectomy or microdiscectomy and in the absence of guideline support. Therefore, this request is not medically necessary.

Post op Physical Therapy 2x8 weeks: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

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