

<b>Case Number:</b>	CM15-0147376		
<b>Date Assigned:</b>	08/10/2015	<b>Date of Injury:</b>	09/26/2013
<b>Decision Date:</b>	09/04/2015	<b>UR Denial Date:</b>	06/24/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/29/2015

### 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 36-year-old female who sustained an industrial injury on 9/26/13. Injury occurred when he slipped and fell while walking backwards and unrolling nylon, landing on his buttocks and hitting his back. Conservative treatment had included medications, activity modification, and epidural steroid injection. The 4/9/15 lumbar spine MRI impression documented bilateral neuroforaminal narrowing at L4/5 secondary to a 2 mm broad-based posterior disc protrusion in conjunction with facet hypertrophy. There was canal stenosis, bilateral exiting nerve root compromise, and posterior annular tear within the intervertebral disc. At L5/S1, there was a posterior annular tear within the intervertebral disc with accompanying 2-3 mm broad-based posterior disc protrusion resulting in bilateral neuroforaminal stenosis and canal stenosis with bilateral exiting nerve root compromise. The 6/15/15 treating physician report indicated that the injured worker had undergone a left L4/5 epidural steroid injection on 5/5/15 with no pain relief. He complained of grade 9/10 back pain radiating down the left leg. Physical exam documented normal gait, normal heel and toe walk, decreased sensation over the left calf, normal motor strength, normal reflex response, and positive left straight leg raise. The diagnosis was lumbar radiculopathy, disc displacement, and degenerative disc disease. The injured worker had failed conservative treatment including no pain relief for epidural steroid injection. Authorization was requested for a lumbar percutaneous discectomy left L4-L5 on an outpatient basis. The 6/24/15 utilization review non-certified the request for the outpatient lumbar percutaneous discectomy left L4-L5 as there were no corroborative motor or sensory deficit on clinical exam and radiculopathy had not been confirmed with electrodiagnostic studies.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Lumbar Percutaneous Discectomy Left L4-L5:** Upheld

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

**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 percutaneous discectomy is 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 back pain radiating down the left leg. Clinical exam findings are consistent with imaging evidence of nerve root compression at the L4/5 and L5/S1 levels. Evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. There was no indication why the L5/S1 level had not been discussed as a possible pain generator given the L4/5 epidural steroid injection resulted in no pain relief. There is no corroborating electrodiagnostic study to confirm radiculopathy at the L4/5 level. Additionally, there is no compelling rationale presented to support the medical necessity of a percutaneous discectomy over standard discectomy or microdiscectomy as an exception to guidelines. Therefore, this request is not medically necessary.

### **Length of stay outpatient:** 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.