

<b>Case Number:</b>	CM15-0205184		
<b>Date Assigned:</b>	10/22/2015	<b>Date of Injury:</b>	08/05/2015
<b>Decision Date:</b>	12/03/2015	<b>UR Denial Date:</b>	10/12/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/20/2015

### 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 54-year-old male who sustained an industrial injury on 8/5/15. Injury occurred when he was getting up and out of a chair and experienced a sudden onset of sharp low back pain radiating down the right leg. Past medical history was positive for ulcerative colitis. Conservative treatment had included activity modification, bracing, hot/cold packs, medications, corticosteroid injection and physical therapy. The 9/17/15 lumbar spine MRI impression documented a large extrusion causing severe nerve root compression at L4/5. It arose from a severely narrowed posterior intervertebral disc space which was partially uncovered from retrolisthesis. There was compression of the ipsilateral nerve roots including the descending right L5 nerve root. The extruded fragment extended behind the majority of the L5 vertebral body with severe left foraminal stenosis and compression of the left L5 exiting nerve root. There was a small extrusion and circumferential bulging at the L3/4 level with intimate contact with the left L4 descending nerve root in the lateral recess. There was a midline extrusion with annular tear causing mild spinal cord compression at T12/L1 with severe subjacent central stenosis and mildly increased T2 signal. There was severe facet arthritis at L5 bilaterally and severe left and moderate right facet arthritis at L4/5. The 9/24/15 spine surgery report cited grade 8/10 persistent low back pain radiating to the right leg with numbness. The injured worker reported a sense of weakness in the leg with weight bearing, difficulty sitting, and difficulty bending over. He had tried 3 weeks of physical therapy with no relief and a corticosteroid injection with no relief. He was working light duty. Medications included tramadol and Flexeril with significant but short term relief. Imaging showed a large extruded

disc herniation extending down behind the L5 vertebral body. On axial views at L4/5, there was a moderately large fairly acute appearing central disc herniation compressing the conus causing some mild ventral flattening of the tip of the spinal cord without foraminal compression. Physical exam documented slow ambulation favoring the right leg and listing to the left. There was restricted and painful lumbar range of motion. Heel and toe walking were restricted by pain. Straight leg raise was positive on the right. Sensation was intact. Motor strength was limited in right foot extension. The diagnosis was acute right lumbar radiculopathy from large extruded right L4/5 disc herniation. He had tried and failed an adequate trial of conservative treatment. With the size of the extruded herniation, it was unlikely that he would get his best recovery without surgery. Authorization was requested for lumbar discectomy at L4/5 on the right with microscope. The 10/12/15 utilization review non-certified the request for lumbar discectomy at L4/5 on the right with microscope as imaging findings were not correlated fully with clinical exam findings.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Lumbar discectomy at L4-5 on the right with microscope: Overturned**

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): General Approach, Surgical Considerations. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back - Lumbar & Thoracic (Acute & chronic): discectomy/laminectomy(2015).

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic: Discectomy/Laminectomy.

**Decision rationale:** The California MTUS recommend surgical consideration when there is severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies (radiculopathy), preferably with accompanying objective signs of neural compromise. Guidelines require clear clinical, imaging and electrophysiologic evidence of a lesion that has been shown to benefit both in the short term and long term from surgical repair. The guidelines recommend that clinicians consider referral for psychological screening to improve surgical outcomes. The Official Disability Guidelines recommend criteria for lumbar discectomy that include symptoms/findings that confirm the presence of radiculopathy and correlate with clinical exam and imaging findings. Guideline criteria include evidence of nerve root compression, imaging findings of nerve root compression, lateral disc rupture, or lateral recess stenosis, and completion of comprehensive conservative treatment. Guideline criteria have been met. This injured worker presents with persistent and function-limiting low back pain radiating down the right leg with numbness and weakness. Clinical exam findings are consistent with imaging evidence of a large extruded disc herniation with nerve root compromise. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. Therefore, this request is medically necessary.