

<b>Case Number:</b>	CM15-0041445		
<b>Date Assigned:</b>	03/11/2015	<b>Date of Injury:</b>	04/19/2005
<b>Decision Date:</b>	05/01/2015	<b>UR Denial Date:</b>	02/23/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/04/2015

### 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: California

Certification(s)/Specialty: Pediatrics, Neurological 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:

The injured worker is a 50-year-old male who reported an injury on 04/19/2005. The mechanism of injury was not specifically stated. The injured worker is currently diagnosed with L5-S1 disc herniation. On 01/23/2015, the injured worker presented for a follow-up evaluation. It was noted that the injured worker was 4 years status post L4-S1 ALIF. The injured worker reported excruciating low back pain with right lower extremity symptoms as well as spasm and numbness in his foot. It was noted that the injured worker does not tolerate opioids and had been recently given a Solu-Medrol injection as well as a Medrol Dosepak. Upon examination, there was an antalgic gait favoring the right lower extremity, 4/5 motor weakness, and diminished ankle reflex on the right. Recommendations at that time included a microdiscectomy at the right L5-S1. Lumbosacral spine x-rays were also recommended at that time. It was noted that the injured worker was previously recommended an epidural steroid injection; however, the provider indicated that an injection would not be beneficial in this case due to lateral and occlusive herniation. A Request for Authorization form was submitted on 02/13/2015. An official x-ray report was submitted on 01/23/2015, which revealed mild multilevel spondylosis. The official MRI of the lumbar spine dated 01/17/2015 was also submitted for review, and revealed evidence of mild disc desiccation at L5-S1 with annular fissuring posterolaterally to the right, a small broad based protrusion, abutment on the foraminal segment of the right L5 root, and no evidence of central canal stenosis or other changes.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Microdiscectomy Right L5-S1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Indications for Surgery - Discectomy/Laminectomy.

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

**Decision rationale:** The California MTUS/ACOEM Practice Guidelines state a referral for surgical consultation is indicated for patients who have severe and disabling lower extremity symptoms; activity limitations for more than 1 month; clear clinical, imaging, and electrophysiologic evidence of a lesion; and a failure of conservative treatment. The Official Disability Guidelines recommend a discectomy/laminectomy when there is objective evidence of radiculopathy upon examination. Imaging studies should reveal evidence of nerve root compression, lateral disc rupture, or lateral recess stenosis. Conservative treatments should include activity modification, drug therapy and epidural steroid injection. There should also be evidence of a referral to physical therapy or manual therapy. In this case, there was no documentation of an exhaustion of recent conservative treatment to include active rehabilitation. In the absence of such documentation of an attempt at conservative treatment in the form of physical therapy or home exercise, the request for a microdiscectomy would not be supported. As such, the request is not medically necessary.

**Pre-Operative Clearance (CXR, CBC, BMP, PT/PTT, EKG): 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.