

<b>Case Number:</b>	CM15-0042952		
<b>Date Assigned:</b>	03/13/2015	<b>Date of Injury:</b>	05/15/2012
<b>Decision Date:</b>	05/01/2015	<b>UR Denial Date:</b>	02/09/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/06/2015

### 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 42-year-old male who reported an injury on 05/15/2012. The mechanism of injury was not provided. The diagnoses include lumbar sprain/strain with radicular complaints and MRI evidence of disc protrusion/extrusion at L4-5. Past treatments include 18 sessions of physical therapy, 12 sessions of acupuncture, epidural injections and use of medications that provided no long term relief. The injured worker reports intermittent moderate low back pain with radiation to both legs. The physical exam from 02/04/2015 notes increased tone and tenderness about the paralumbar musculature with tenderness at the midline thoracolumbar junction and over the level of L4-5 facets and right S1 joint. There are muscle spasms. The injured worker's range of motion at forward flexion is 70 degrees, extension 20 degrees, right lateral flexion 25 degrees, left lateral flexion 20 degrees, and right and left rotation at 20 degrees. There is a positive straight leg raise on the right side. There was also a positive Patrick Faber's test, Kemp's test and Braggart's test. The injured worker had 2+ reflexes on the left and right as well as normal sensation in the L1-S1 dermatomes except in the area of the L5-S1 dermatome on the right where it was decreased. The right lower extremity was decreased in strength at 3+/5. The MRI from 12/18/2014 notes that there was asymmetric 3 to 4 mm broad based disc bulge with focal right paracentral/lateral prominence, causing mild to moderate right neural foraminal narrowing. There was L5-S1 2 mm central disc protrusion, causing no significant neural foraminal narrowing or canal stenosis. There were hypertrophic facet degenerative changes seen. At the L3-4 level there was a 3 mm central disc protrusion with annular tear, causing no significant neural foraminal narrowing or canal stenosis. There was

multilevel disc degeneration noted. The Electrodiagnostic Study Report from 10/09/2013 notes that there was evidence of acute bilateral L4, L5 and S1 lumbosacral radiculopathy. There was no evidence of peripheral neuropathy or entrapment neuropathy in both lower extremities. The injured worker was seen for spinal consultation and surgery was recommended; however, the injured worker wanted to hold off at the time.

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

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

#### **L3-4, L4-5 and L5-S1 Microdiscectomy left sided and right sided hemilaminotomy foraminotomy decompression: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 299 and 305-307.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back, Discectomy/laminectomy.

**Decision rationale:** The injured worker has tenderness around the paralumbar musculature with tenderness at the midline thoracolumbar junction and over the level of L4-5 facets and right S1 joint. There was a decrease in lumbar range of motion and a positive straight leg raise. The injured worker had normal deep tendon reflexes with a decreased sensation at the L5-S1 dermatome on the right. The Official Disability Guidelines recommend discectomy and laminectomy for patients that have confirmed presence of radiculopathy. Objective findings on examination need to be present. The indication of nerve root compression is to be indicated with unilateral weakness on the affected side. There needs to be imaging studies that correlate the findings as well as a failed conservative treatment documented. The documentation does note that the injured worker has decreased strength in the right lower extremity as well as moderate to right neural foraminal narrowing. There is also documentation of the L5-S1 dermatome having decreased sensation on the right. There was no documentation that the injured worker has any weakness on the left side. There was also no documentation that the injured worker has a positive straight leg raise on the left as well as there are no decreased reflexes or sensation on the left. Therefore, the request for L3-4, L4-5 and L5-S1 microdiscectomy left sided and right sided hemilaminectomy foraminotomy decompression is not medically necessary.

#### **Post Operative Cryotherapy 2 times a week for 6 weeks: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

**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.

#### **Post Physical Therapy 2 itmes a week for 6 weeks: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

**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.