

Case Number:	CM15-0051144		
Date Assigned:	03/24/2015	Date of Injury:	11/09/2010
Decision Date:	05/05/2015	UR Denial Date:	03/06/2015
Priority:	Standard	Application Received:	03/18/2015

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: Minnesota, Florida
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:

The injured worker is a 58 year old male, who sustained an industrial injury on 11/09/2010. Treatment and diagnostics to date have included MRI of the lumbar spine in 2011, acupuncture, medications, and a spinal cord stimulator trial. The spinal cord stimulator trial was successful with reported 80 percent pain relief. Currently, the injured worker complains of right leg numbness down the right lateral leg and foot, back pain in the middle of the back, and shoulder pain. MRI showed right L5-S1 foraminal stenosis with a small herniated disc. He also had some foraminal stenosis at upper lumbar levels. The provider recommended a right L5-S1 microlumbar discectomy. Diagnoses included chronic low back pain and L5/S1 disc herniation foraminal stenosis. A recent MRI scan of the lumbar spine has been performed but the report was not included. There is no documentation of radiculopathy on EMG. The last EMG in 2011 was negative.

IMR ISSUES, DECISIONS AND RATIONALES

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

L5 Microlumbar Discectomy Qty: 1.00: 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): 305, 306, 307.

Decision rationale: The injured worker is a 58-year-old male with a history of low back pain for the past 4 years. Pain management notes dated 8/19/2014 reported status post spinal cord stimulator trial on 8/13/2014 which improved pain relief by 80%. On September 12, 2014 he reported great temporary pain relief from acupuncture. His pain with medication was 3/10. 8 sessions of acupuncture were completed. On September 18, 2014 his pain level was 4/10 with pain primarily in the lower back. Straight leg raising was positive at 90 bilaterally in the sitting position. Sensory examination reported decreased light touch sensation in the L4, L5, and S1 dermatomes on the right side. Motor examination revealed slight decrease in the strength in the knee flexors at 4/5 on the left. The knee flexors strength was 5/5 on the right. Knee extension was 4/5 bilaterally. Deep tendon reflexes were not documented. A neurosurgery consultation dated 10/2/2014 is noted. He was complaining of low back pain for the past 4 years from a work-related injury. He had seen other specialists who recommended back surgery but he wanted to try other treatments first. He had tried a spinal cord stimulator and found it helpful and would like to try the procedure again. He was also experiencing neck pain. On examination there was clonus noted in the right leg which may be related to neck pain. Pain management notes dated 10/7/2014 include an unofficial MRI report from 6/17/2011 which showed a small right paramedian posterior lateral subligamentous L5-S1 disc herniation associated with a large osteophyte causing severe right L5-S1 neural foraminal stenosis and posterior displacement on the right S1 nerve root. There was mild L3-4 and minimal L2-3 and L4-5 central spinal stenosis due to facet and ligamentous disease. Electromyography of the lower extremities performed on 8/7/2011 was normal. There was no evidence of radiculopathy. A follow-up visit of 11/17/2014 documented pain levels of 8/10 in the lower back. It was radiating to the right thigh, right leg and right foot. On examination range of motion of the lumbar spine was restricted with flexion limited to 30 and extension limited to 10. Sensory examination reported decreased light touch over L4, L5, and S1 dermatomes on the right side. Motor testing revealed knee flexors 5/5 on the right and 4/5 on the left, knee extensors 4/5 on the right and 4/5 on the left. The remaining motor examination is not included. Deep tendon reflexes are also not included. Subsequent notes document a request for MRI scan of the lumbar spine. On 2/19/2015 a neurosurgery consultation follow-up is noted. The notes indicate MRI finding of a small herniated disc at L5-S1 but this did not explain his symptoms. The notes are not clear with regard to the date of the MRI. His symptoms were primarily in the low back and right leg. He had mainly right leg numbness down the lateral aspect of the leg and foot. The provider believed that spinal cord stimulator was an effective treatment for him but a peer review advised that discectomy would seem more appropriate. The California MTUS guidelines indicate surgical considerations for severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies (radiculopathy), preferably with accompanying objective signs of neural compromise, activity limitations due to radiating leg pain for more than one month or extreme progression of lower leg symptoms, clear clinical, imaging, and electrophysiologic evidence of a lesion that has been shown to benefit in both the short and long-term from surgical repair, and failure of conservative treatment to resolve disabling radicular symptoms. The documentation indicates an MRI scan in 2011 and a repeat study in 2015 but the official reports have not been submitted. Electrophysiologic studies in the past were negative for radiculopathy. No recent

study is documented. There is no clear clinical, imaging, and electrophysiologic evidence of a lesion that has been shown to benefit from surgery. Severe and disabling lower leg symptoms are not documented. Most of the pain is reported to be in the lower back. Although sensory deficit is reported in the right L4, L5, and S1 dermatomes, this is not corroborated by MRI findings which show a small herniation at L5-S1 on the right. There is no electrophysiologic evidence of radiculopathy. The guideline criteria for surgery have not been met. As such, the request for microdiscectomy at L5-S1 on the right is not medical necessary.

S1 Microlumbar Discectomy Qty: 1.00: 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): 305, 306, 307.

Decision rationale: The injured worker is a 58-year-old male with a history of low back pain for the past 4 years. Pain management notes dated 8/19/2014 reported status post spinal cord stimulator trial on 8/13/2014 which improved pain relief by 80%. On September 12, 2014 he reported great temporary pain relief from acupuncture. His pain with medication was 3/10. 8 sessions of acupuncture were completed. On September 18, 2014 his pain level was 4/10 with pain primarily in the lower back. Straight leg raising was positive at 90 bilaterally in the sitting position. Sensory examination reported decreased light touch sensation in the L4, L5, and S1 dermatomes on the right side. Motor examination revealed slight decrease in the strength in the knee flexors at 4/5 on the left. The knee flexors strength was 5/5 on the right. Knee extension was 4/5 bilaterally. Deep tendon reflexes were not documented. A neurosurgery consultation dated 10/2/2014 is noted. He was complaining of low back pain for the past 4 years from a work-related injury. He had seen other specialists who recommended back surgery but he wanted to try other treatments first. He had tried a spinal cord stimulator and found it helpful and would like to try the procedure again. He was also experiencing neck pain. On examination there was clonus noted in the right leg which may be related to neck pain. Pain management notes dated 10/7/2014 include an unofficial MRI report from 6/17/2011 which showed a small right paramedian posterior lateral subligamentous L5-S1 disc herniation associated with a large osteophyte causing severe right L5-S1 neural foraminal stenosis and posterior displacement on the right S1 nerve root. There was mild L3-4 and minimal L2-3 and L4-5 central spinal stenosis due to facet and ligamentous disease. Electromyography of the lower extremities performed on 8/7/2011 was normal. There was no evidence of radiculopathy. A follow-up visit of 11/17/2014 documented pain levels of 8/10 in the lower back. It was radiating to the right thigh, right leg and right foot. On examination range of motion of the lumbar spine was restricted with flexion limited to 30 and extension limited to 10. Sensory examination reported decreased light touch over L4, L5, and S1 dermatomes on the right side. Motor testing revealed knee flexors 5/5 on the right and 4/5 on the left, knee extensors 4/5 on the right and 4/5 on the left. The remaining motor examination is not included. Deep tendon reflexes are also not included. Subsequent notes document a request for MRI scan of the lumbar spine. On 2/19/2015 a neurosurgery consultation follow-up is noted. The notes indicate MRI finding of a small herniated disc at L5-S1 but this did not explain his symptoms. The notes are not clear with regard to the date of the

MRI. His symptoms were primarily in the low back and right leg. He had mainly right leg numbness down the lateral aspect of the leg and foot. The provider believed that spinal cord stimulator was an effective treatment for him but a peer review advised that discectomy would seem more appropriate. The California MTUS guidelines indicate surgical considerations for severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies (radiculopathy), preferably with accompanying objective signs of neural compromise, activity limitations due to radiating leg pain for more than one month or extreme progression of lower leg symptoms, clear clinical, imaging, and electrophysiologic evidence of a lesion that has been shown to benefit in both the short and long-term from surgical repair, and failure of conservative treatment to resolve disabling radicular symptoms. The documentation indicates an MRI scan in 2011 and a repeat study in 2015 but the official reports have not been submitted. Electrophysiologic studies in the past were negative for radiculopathy. No recent study is documented. There is no clear clinical, imaging, and electrophysiologic evidence of a lesion that has been shown to benefit from surgery. Severe and disabling lower leg symptoms are not documented. Most of the pain is reported to be in the lower back. Although sensory deficit is reported in the right L4, L5, and S1 dermatomes, this is not corroborated by MRI findings which showed a small herniation at L5-S1 on the right. There is no electrophysiologic evidence of radiculopathy. No deep tendon reflex change supporting the clinical diagnosis of radiculopathy is reported. The guideline criteria for surgery have not been met. As such, the request for microdiscectomy at L5-S1 on the right is not medical necessary.