

<b>Case Number:</b>	CM15-0062379		
<b>Date Assigned:</b>	04/08/2015	<b>Date of Injury:</b>	09/09/2009
<b>Decision Date:</b>	05/19/2015	<b>UR Denial Date:</b>	03/16/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/02/2015

### 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 65-year-old male who sustained an industrial injury on 9/9/09. Injury occurred when he tried to climb off a machine and his left foot became caught and he slipped. He grabbed a handle to break his fall and experienced immediate pain to his low back, left hip and left knee. Past medical history was positive for diabetes. The 8/8/14 lumbar spine MRI impression documented mild bilateral lateral recess stenosis at L5/S1 secondary to a broad-based disc protrusion with no definite central canal or nerve root compression seen. Findings documented mild intervertebral disc desiccation at L2/3, L3/4 and L4/5 with no focal disc bulge or disc protrusion, no central canal or neuroforaminal stenosis, and mild hypertrophic changes in the facet joints. The 2/16/15 treating physician report cited worsening low back pain and left lower extremity radiculopathy. Significant functional difficulty was noted in activities of daily living and sleeping. MRI images were reviewed and showed disc desiccation at the L4/5 level as well as foraminal stenosis on the left sided at L4/5 on the axial views. Surgical intervention with lumbar micro-decompression on the left L4/5 was recommended. The 3/16/15 utilization review non-certified the request for lumbar micro-decompression of left L4/5 as there was no documentation of physical exam findings correlated with L4/5 nerve root impingement. The 3/24/15 treating physician report documented review of the images of the lumbar spine MRI with disc desiccation at the L4/5 on the sagittal T2 images as well as foraminal stenosis on the left side at L4/5 level on axial T2 images. He stated that the available images of the lumbar MRI do not correlate with the report of the same MRI. Moreover, the findings of the MRI images do not correlate with findings of the physical exam with decreased sensation and pain in the left L5

dermatomal distribution. Appeal of the surgical denial was requested. The 3/30/15 treating physician report cited increased grade 8-9/10 low back pain and spasms radiating to the left lower extremity with numbness, weakness and tingling. The injured worker experienced weakness and instability in the left leg after walking one block. Difficulty was reported with bending, stooping, squatting, and prolonged standing/walking. Physical exam documented decreased lumbar flexion/extension, decreased left L5 and L4 dermatome sensation with pain, and slightly reduced left lower extremity deep tendon reflexes. There was 4/5 weakness in left knee flexion, extension, plantar flexion and dorsiflexion. Straight leg raise was positive at 40 degrees on the left. The MRI report documented mild disc desiccation at L4/5. However, MRI images were reviewed in December and February and confirmed L4/5 disc desiccation with left neuroforaminal stenosis. The injured worker was an appropriate candidate for left L5/S1 lumbar decompression. He had extensive conservative treatment for over 6 months.

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

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

#### **1 lumbar micro-decompression of left L4-5: Overturned**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 306. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back - Lumbar & Thoracic (Acute & Chronic).

**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 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 in both 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 reasonably met. This injured worker presents with persistent low back and left lower extremity pain consistent with an L4/5 radiculopathy. The treating physician has documented imaging evidence of disc desiccation and left sided foraminal stenosis, which are consistent with clinical exam findings. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. Epidural steroid injection is not indicated, as the injured worker is a diabetic with prior reaction to corticosteroids. Therefore, this request is medically necessary.