

<b>Case Number:</b>	CM13-0002535		
<b>Date Assigned:</b>	12/04/2013	<b>Date of Injury:</b>	01/02/2011
<b>Decision Date:</b>	01/17/2014	<b>UR Denial Date:</b>	04/24/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/22/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in California. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 patient is a 54-year-old female with a reported date of injury of 01/02/2012. The mechanism of injury is described as a falling injury at work. She was seen on 07/09/2012 for electrodiagnostic studies, and this was considered an abnormal study as there were spontaneous activities in the paraspinal muscles expected after spinal surgery and thought to be possibly related to lumbar radiculopathy. An initial neurosurgical evaluation on 01/16/2013 found this patient to have a positive history for spinal decompression and fusion in 2004, and on exam, she had deep tendon reflexes that were abnormal in the bilateral upper extremities, and in the lower extremities they were 1/4 bilaterally. They were unequal and brisker on the left. There were sensory deficits at left L4-5 and L5-S1, and in the lower extremities there were motor deficits at the bilateral L5-S1 as well as the right L3-4 and L4-5 levels. Arthroscopic decompression of the nerve roots at both L4-5 and L5-S1 was recommended to her. She returned for electrodiagnostic studies on 08/05/2013, and again there was spontaneous activity in the paraspinal muscles, expected after spinal surgery and also consistent with lumbar radiculopathy. On 09/30/2013, she was found to have palpable tenderness with evidence of muscle spasms and decreased range of motion as the only objective findings noted. The CT of the lumbar spine on 10/22/2013 revealed (1) at L4-5, there was a 3 mm to 4 mm disc bulge contributing to mild bilateral foraminal stenosis; (2) at L5-S1, she was status post anterior discectomy with intervertebral body space replacement, anterior instrumentation, decompressive laminectomy, bipedicular screws, and interconnecting rods; (3) there was grade I anterolisthesis present and there was a solid continuous intervertebral body and posterior element bony fusion; (4) the spinal canal and neural foramina were patent at that level. Diagnoses included lumbosacral spine discogenic disease, lumbar spine radiculopathy, st

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Microscopic decompression of the nerve roots at L4-L5 and L5-S1:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-306.

**Decision rationale:** This request is for microscopic decompression of the nerve roots at L4-L5 and L5-S1. The most recent CT dated 10/22/2013 revealed a 3 mm to 4 mm disc bulge at L4-5 that contributed to mild bilateral foraminal stenosis. At L5-S1, she was found to have a previous anterior discectomy with fusion, and the spinal canal and neural foramina were patent at L5-S1. MTUS/ACOEM indicates that there should be clear clinical imaging and electrophysiological evidence of a lesion that has been shown to benefit in both the short and long term from surgical repair prior to undergoing this surgical procedure. The electrodiagnostic study is not confirmatory but only suggests lumbar radiculopathy. Therefore, there is no clear imaging or electrophysiological evidence of a lesion that would benefit from surgical intervention. The last clinical exam fails to elicit any significant functional deficits such as motor weakness, sensory changes, or reflex changes, and only indicates that she has tenderness, muscle spasms, and decreased range of motion. As such, there is no clear physical examination that would document that the surgical procedure should take place. As such, this request is not considered medically necessary per MTUS/ACOEM, and it is non-certified.