

<b>Case Number:</b>	CM14-0019411		
<b>Date Assigned:</b>	04/21/2014	<b>Date of Injury:</b>	11/18/1999
<b>Decision Date:</b>	07/02/2014	<b>UR Denial Date:</b>	02/11/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/14/2014

### 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. The expert reviewer is Board Certified in Orthopedic Surgery 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 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/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:

The injured worker is a 51-year-old female who sustained an injury in November 11, 1999. The current diagnosis is lumbar spinal stenosis (724.02). A minimally invasive decompression laminectomy is suggested at two separate levels. The mechanism of injury was noted to be a lifting event. There were complaints of neck and back pain beginning in July, 2013. Treatment to date has included physical therapy, medications, and other conservative measures. The physical examination noted a marked decrease in lumbar spine range of motion however motor and sensory were intact. Imaging studies identified posterior facet osteoarthritis from L3 through S1. Disc desiccation has also been described. Straight leg raise test was reported to be positive at 45. The January, 2014 progress note from the neurosurgeon indicated physical therapy failed to ameliorate the symptomology. There were worsening lumbar symptoms. There was right lower extremity involvement with numbness and tingling into the great toe. The physical examination noted an altered gait pattern, heel and toe walking cannot be accomplished, a marked reduction in lumbar spine range of motion. A slight weakness and quadriceps is reported. Decreased sensation is also noted in the anterior distal right lower extremity. Plain films do not identify any scoliosis or spondylolisthesis. A lateral recess stenosis is reported on lumbar MRI. This was due to facet hypertrophy. The MRI narrative indicated a tiny disc protrusion at L5/S1, minimal endplate degeneration from L2 through L5 with mild lower facet (enlargement) hypertrophy. A September, 2013 progress note indicated a ten year history of chronic neck and low back pain with a cervical fusion surgery having been completed approximately ten years prior. A generalized weakness and discomfort is noted. The radicular symptoms are reported to be "non-dermatomal". It is noted that the injured employee does not work.

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

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

### **RIGHT L3-L4 AND L4-L5 MINIMALLY INVASIVE LATERAL RECESS**

**DECOMPRESSION:** 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.

**Decision rationale:** When noting the date of injury, the mechanism of injury, the treatment today, the ongoing complaints of pain, the marginal findings noted on MRI and inconsistency with the physical examination findings, there is no clinical data presented to support surgical intervention multiple levels lumbar spine. There are ongoing complaints of low back pain associated with right lower extremity symptoms. However the MRI clearly indicates changes are minimal and no specific nerve root encroachment or facet joint compromise is identified. As outlined in the American College of Occupational and Environmental Medicine (ACOEM) guidelines, surgical options are for those with persistent and severe sciatica and clinical evidence of nerve root compromise. Seeing none, there is no clinical indication for this request.