

<b>Case Number:</b>	CM14-0074797		
<b>Date Assigned:</b>	07/16/2014	<b>Date of Injury:</b>	01/15/2009
<b>Decision Date:</b>	09/17/2014	<b>UR Denial Date:</b>	05/06/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/22/2014

### 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:

This is a 57 year-old male with an 11/15/2009 date of injury. He was injured during his normal occupation and there was no single traumatic event. He reports that his job as a machine operator is strenuous and repetitive in nature and he noticed low back pain beginning in July 2007. In a report dated 10/22/2013, the patient describes constant 4-7/10 low back pain with radiation into the lower extremities. Physical exam demonstrated a positive SLR at 60 degrees bilaterally, intact reflexes, decreased sensation of bilateral S1 dermatomes, and 5/5 strength testing bilaterally. Prior reports show 4/5 strength in certain lower extremity muscle groups but these are inconsistent and do not appear reproducible. X-ray from 06/15/2012 shows moderate to severe discogenic and degenerative disease at multiple levels, worst at L4/5 with anterior slippage of L4, consistent with mild spondylolisthesis. The MRI from 20/26/2013 shows disc bulges of 2.3 mm seen at L3/4, L4/5, and L5/S1 causing bilateral neural foraminal narrowing as well as spinal canal narrowing. There is disc desiccation at L3/4 down to L5/S1 levels. EMG/NCV from 05/23/2012 indicates mild left tibial nerve injury, and bilateral S1 radiculopathy. Diagnostic impression reveals multilevel discogenic lumbar spine disease and lumbar radiculopathy. Treatment to date includes medical management, acupuncture, 3 epidural spinal injections without relief, lumbar support, inferential unit, and hot/cold therapy. A utilization review decision on 05/05/2014 denied the request for decision to remove spine lamina lumbar on the basis that it was not specific enough and lacked appropriate CPT codes.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Remove spine lamina 1/2 lumbar:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Weinstein, Surgical versus non-operative treatment for lumbar disc herniation.

**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 Chapter.

**Decision rationale:** The MTUS states that surgical intervention is recommended for patients who have severe and disabling lower leg symptoms in the 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. Unfortunately, there is no additional documentation that helps to describe the exact nature of the surgery requested. In addition, there is weak evidence in the documentation that the patient has a specific, reproducible motor deficit in the lower extremities. Objective, unequivocal evidence of radiculopathy is lacking, and the exam findings do not correlate with imaging findings for nerve root dysfunction. Therefore, the request to remove spine lamina lumbar is not medically necessary.