

<b>Case Number:</b>	CM15-0109306		
<b>Date Assigned:</b>	06/15/2015	<b>Date of Injury:</b>	06/11/2007
<b>Decision Date:</b>	07/14/2015	<b>UR Denial Date:</b>	05/05/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/05/2015

### 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: New Jersey, Alabama, California  
 Certification(s)/Specialty: Neurology, Neuromuscular Medicine

### 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 63-year-old male, who sustained an industrial injury on 6/11/2007. The mechanism of injury is documented as a motor vehicle accident. The injured worker was diagnosed as having a lumbar hemi-laminectomy in 2011 and lumbar discogenic disease-status post laminectomy. Computed tomography myelogram showed severe lumbosacral degenerative disc disease, lumbar 4-5 stenosis and lumbar 3-4 retrolisthesis. Treatment to date has included surgery, physical therapy and medication management. In a progress note dated 4/20/2015, the injured worker complains of low back pain that radiates to the right lower extremity. Physical examination showed lumbar pain with range of motion. The treating physician is requesting lumbar 3-5/S1 laminectomy with right lumbar 3/4, 4/5 lumbar 5/sacral 1 posterior oblique lumbar with posterolateral fusion and instrumentation.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**L3/3/5/S1 laminectomy with right L3/4 L4/5 L5/S1 posterior oblique lumbar with posterolateral fusion and instrumentation: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Discectomy/ laminectomy. <http://www.odg-twc.com/index.html>.

**Decision rationale:** According to ODG guidelines, indication for lumbar laminectomy: ODG Indications for Surgery Discectomy/laminectomy: Required symptoms/findings; imaging studies; & conservative treatments below: I. Symptoms/Findings which confirm presence of radiculopathy. Objective findings on examination need to be present. Straight leg raising test, crossed straight leg raising and reflex exams should correlate with symptoms and imaging. Findings require ONE of the following: A. L3 nerve root compression, requiring ONE of the following: 1. Severe unilateral quadriceps weakness/mild atrophy. 2. Mild-to-moderate unilateral quadriceps weakness. 3. Unilateral hip/thigh/knee pain. B. L4 nerve root compression, requiring ONE of the following: 1. Severe unilateral quadriceps/anterior tibialis weakness/mild atrophy. 2. Mild-to-moderate unilateral quadriceps/anterior tibialis weakness. 3. Unilateral hip/thigh/knee/medial pain. C. L5 nerve root compression, requiring ONE of the following: 1. Severe unilateral foot/toe/dorsiflexor weakness/mild atrophy. 2. Mild-to-moderate foot/toe/dorsiflexor weakness. 3. Unilateral hip/lateral thigh/knee pain. D. S1 nerve root compression, requiring ONE of the following: 1. Severe unilateral foot/toe/plantar flexor/hamstring weakness/atrophy. 2. Moderate unilateral foot/toe/plantar flexor/hamstring weakness. 3. Unilateral buttock/posterior thigh/calf pain (EMGs are optional to obtain unequivocal evidence of radiculopathy but not necessary if radiculopathy is already clinically obvious.) II. Imaging Studies, requiring ONE of the following, for concordance between radicular findings on radiologic evaluation and physical exam findings: A. Nerve root compression (L3, L4, L5, or S1). B. Lateral disc rupture. C. Lateral recess stenosis. Diagnostic imaging modalities, requiring ONE of the following: 1. MR imaging. 2. CT scanning. 3. Myelography. 4. CT myelography & X-Ray. III. Conservative Treatments, requiring ALL of the following: A. Activity modification (not bed rest) after patient education (> 2 months). B. Drug therapy, requiring at least ONE of the following: 1. NSAID drug therapy. 2. Other analgesic therapy. 3. Muscle relaxants. 4. Epidural Steroid Injection (ESI). C. Support provider referral, requiring at least ONE of the following (in order of priority): 1. Physical therapy (teach home exercise/stretching). 2. Manual therapy (chiropractor or massage therapist). 3. Psychological screening that could affect surgical outcome. 4. Back school (Fisher, 2004.). For average hospital LOS after criteria are met, see Hospital length of stay (LOS). There is no recent clinical, radiological and electrodiagnostic evidence lumbar root compression in this case. There is no evidence of radiculopathy, lumbar stenosis or lumbar instability. There is no recent and objective documentation of failure of conservative therapies and injections. Therefore, the request for L3/3/5/S1 laminectomy with right L3/4 L4/5 L5/S1 posterior oblique lumbar with posterolateral fusion and instrumentation is not medically necessary.