

<b>Case Number:</b>	CM15-0053211		
<b>Date Assigned:</b>	03/26/2015	<b>Date of Injury:</b>	10/21/2011
<b>Decision Date:</b>	05/06/2015	<b>UR Denial Date:</b>	03/06/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/20/2015

### 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: Minnesota, Florida  
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:

The injured worker (IW) is a 49 year old male who sustained an industrial injury on 10/21/2011. He reported low back and right shoulder pain. The injured worker diagnoses include cervical radiculopathy, lumbar radiculopathy, and right shoulder impingement syndrome. Treatment to date has included Lidoderm patches, Vicodin, Soma and Tylenol #3. Currently, the injured worker complains of low back pain that radiates to both legs as well as neck pain radiating to both arms. The treatment plan includes a C5-C7 Anterior cervical discectomy and fusion (ACDF), and a L1-S1 laminectomy. Medications were prescribed for pain control and a request for authorization was made on 2/20/2015 for a L1-S1 Laminectomy. However, the utilization review and IMR requests pertain to "L5-S1 laminectomy".

### IMR ISSUES, DECISIONS AND RATIONALES

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

**L5-S1 Laminectomy:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 30.

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

**Decision rationale:** With regard to the request for L1-S1 laminectomy a QME of December 3, 2014 is noted. He was complaining of neck pain radiating into both upper extremities as well as low back pain radiating to both lower extremities. The symptoms started 3 years ago. He had minimal improvement with anti-inflammatories, physical therapy, and epidural injections. Acupuncture did not help. His pain was described as 10 out of 10. Examination of the lumbar spine at that time revealed tenderness to palpation over the paraspinal musculature. Inspection revealed normal lordosis. Flexion was 60/60 and extension was 25/25. Right bend was 25/25 and left bend was 25/25. There was no tenderness to palpation over the spinous processes. Examination of the lower extremities revealed diminished sensation over bilateral L5 dermatomes. Reflexes were 2+ at the knees and ankles. There was no clonus. The assessment was cervical radiculopathy and lumbar radiculopathy. MRI scans of the cervical and lumbar spine were recommended. A right shoulder MRI was also recommended. A CT of the lumbar spine was performed on December 18, 2014. The findings included posterior disc protrusions at all levels from L1-S1. At L5-S1 there was posterior disc protrusion and osteophytic complex without effacing the thecal sac. Bilateral neural foraminal narrowing was seen. A subsequent follow-up examination of 2/28/2015 is noted. Examination of the lumbar spine revealed tenderness to palpation over the paraspinal musculature. Range of motion was again normal. There was no tenderness to palpation over the spinous processes. Examination of the lower extremities revealed diminished sensation over bilateral L5 dermatomes. Reflexes were 2+ in the patellae and Achilles. Negative Achilles clonus. Negative straight leg raising. Authorization was requested for L1-S1 laminectomy as he had multiple level stenosis on MRI. California MTUS guidelines indicate surgical considerations for severe and disabling lower leg symptoms in a 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 to resolve disabling radicular symptoms. Direct methods of nerve root decompression included laminotomy, standard discectomy, and laminectomy. Patients with comorbid conditions may be poor candidates for surgery. Comorbidities should be weighed and discussed carefully with the patient. In this case there is no clear clinical, imaging, and electrophysiologic evidence of a lesion that is shown to benefit in both the short and long-term from surgical repair. Electrophysiologic studies have not been done. The findings on the imaging studies do not include evidence of nerve root compression from L1-S1 bilaterally. The clinical examination does not support evidence of bilateral radiculopathy from L1-S1. As such, the request for L1-S1 laminectomy is not supported and the medical necessity of the request has not been substantiated. This IMR request pertains to a specific UR denial of laminectomy at L5-S1. The documentation indicates hypesthesia in the L5 distribution bilaterally. Straight leg raising was negative. Deep tendon reflexes were 2+ bilaterally in the knees and 2+ bilaterally in the ankles. No objective motor neurologic deficit is documented. There is no electrophysiologic evidence of S1 radiculopathy. The imaging study does not show evidence of nerve root impingement at this level. As such, the request for L5-S1 laminectomy as stated is not supported and the medical necessity is not established.