

<b>Case Number:</b>	CM15-0058357		
<b>Date Assigned:</b>	04/03/2015	<b>Date of Injury:</b>	11/01/2007
<b>Decision Date:</b>	05/12/2015	<b>UR Denial Date:</b>	03/25/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/27/2015

### 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, Michigan, 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 62 year old female injured worker suffered an industrial injury on 11/01/2007. The diagnoses included recurrent carpal tunnel syndrome, recurrent cervical strain, lumbosacral spine degenerative disc disease with right radiculopathy and right lower extremity neurogenic claudication. The diagnostics included cervical/lumbar x-rays and lumbar magnetic resonance imaging and electromyographic studies. The injured worker had been treated with physical therapy. On 12/15/2014 the treating provider reported low back pain and right lower extremity pain. She has occasional stiffness and strongly feels the left leg is getting worse with difficulty walking and the leg giving out. The telephonic conversation on 3/11/2014 by the provider to the injured worker recommended laminectomy due to the spinal cord being tethered via the lumbar magnetic resonance imaging of the lumbar spine. The treatment plan included L5-S1 Laminectomy and 4 In-Patient Stay (Days).

### 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 Chronic Pain Treatment Guidelines.

**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 the Official Disability Guidelines (ODG), 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: 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 ( $\geq 2$  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) There is no recent clinical, radiological and electrodiagnostic evidence lumbar root compression in this case. There is no recent and objective documentation of failure of conservative therapies and injections. Therefore, the request for L5-S1 Laminectomy is not medically necessary.

**Associated Surgical Service: 4 In-Patient Stay (Days):** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**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:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.