

<b>Case Number:</b>	CM15-0061792		
<b>Date Assigned:</b>	04/07/2015	<b>Date of Injury:</b>	10/25/2012
<b>Decision Date:</b>	05/12/2015	<b>UR Denial Date:</b>	03/17/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/01/2015

### 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 York  
 Certification(s)/Specialty: Neurological 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 is a 30 year old male patient on 10/25/2012 reported back pain after unloading 60 pound bags of concrete. The AME (Agreed upon medical examiner) report of 2/20/14 noted a release to modified work after completion of chiropractic treatment on 3/24/13. The PR2 of 04/23/13 noted good relief of pain in his legs but low back pain was rated at 6/10. The PR2 of 9/12/2013 indicated physical therapy had been ineffective in alleviating his pain which was 7/10 and a psychiatric consult had been requested. The patient continued on narcotics. The MRI scan of 01/11/13 described at L4-5 a 3-4 mm lumbar disc protrusion which mildly narrowed the left lateral recess and minimally encroached on the right. At L5-S1 there was a 3-4 mm central disc protrusion. A primary treating office visit dated 10/03/2014 reported the patient taking the following medications: Robaxin, Tramadol, Gabapentin, Vicodin, Ultram, Zanaflex, Motrin and Flexeril. He has undergone lumbar magnetic resonance imaging, psychological evaluation, facet injections. He is diagnosed with degenerative disc disease of lumbar spine; lumbar radiculopathy, and lower back pain. The MRI scan of 3/10/15 noted no spondylolysis or spondylolisthesis at L4-5 and L5-S1 but found degenerative disc disease with posterior annular tears but no nerve root displacement or impingement by the broad based disc bulges. The central canal was noted to patent at both levels. The plan of care involved: recommendation of surgical intervention. Of note, the provider felt the patient has failed conservative measures; has been denied physical therapy, chiropractic therapy and aqua therapy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Microdecompression at L4-5: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307.

**Decision rationale:** The California MTUS guidelines note that surgical consultation is indicated if the patient has persistent, severe and disabling lower extremity symptoms. The documentation shows this patient has been complaining of pain in the back primarily. Documentation does not disclose disabling lower extremity symptoms. The guidelines also list the criteria for clear clinical, imaging and electrophysiological evidence consistently indicating a lesion which has been shown to benefit both in the short and long term from surgical repair. Documentation does not show this evidence. The requested treatment is for a microdecompression at L4-5. The MRI scan of 3/10/15 did not show a herniated lumbar disc or nerve root impingement. The requested treatment: Microdecompression at L4-5 is not medically necessary and appropriate.

**Associated Surgical Service: One day hospital stay: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

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

**Microdecompression at L5-S1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307.

**Decision rationale:** The California MTUS guidelines note that surgical consultation is indicated if the patient has persistent, severe and disabling lower extremity symptoms. The documentation shows this patient has been complaining of pain in the back primarily. Documentation does not disclose disabling lower extremity symptoms. The guidelines also list the criteria for clear clinical, imaging and electrophysiological evidence consistently indicating a lesion which has been shown to benefit both in the short and long term from surgical repair. Documentation does not show this evidence. The requested treatment is for a microdecompression at L5-S1. The

MRI scan of 3/10/15 did not show a herniated lumbar disc or nerve root impingement. The requested treatment: Microdecompression at L5-S1 is not medically necessary and appropriate.

**Associated Surgical Services: Microsurgical techniques, requiring use of operating microscope:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

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