

Case Number:	CM13-0028564		
Date Assigned:	01/10/2014	Date of Injury:	12/22/2011
Decision Date:	03/20/2014	UR Denial Date:	09/03/2013
Priority:	Standard	Application Received:	09/25/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Orthopedic Surgery, Fellowship trained in Spine Surgery and is licensed to practice in California and Texas. 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 physician 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:

The patient is a 52-year-old male who reported injury on 12/22/2011. The mechanism of injury was noted to be the patient was on a roof getting into position and slipped and twisted his low back and right hip. The patient underwent physical therapy and epidural steroid injections. The patient had a CT scan on 06/20/2013 which revealed at L2-3 facet arthropathy, grade 1 spondylolisthesis and severe central stenosis; at L3-4, there was a broad based disc bulge, left central protrusion, facet arthropathy, and moderately severe central stenosis. The patient had an MRI on 09/11/2013 which revealed at the level of L2-3, there was disc desiccation with a loss of disc height and grade posterior slip of L3 on L2 with diffuse disc protrusion with a prominent left paracentral component with ligamentum flavum hypertrophy and posterior facet arthropathy causing severe canal stenosis and moderate to severe left and mild right exit foramen narrowing; there was narrowing of both lateral recesses and was unchanged from the prior examination in 2012; at the level of L3-4, there was a small diffuse disc protrusion with mild ligamentum flavum hypertrophy causing moderate to severe canal stenosis, the thecal sac and the AP dimensions measured 5 to 6 mm; the posterior epidural fat measured another 4 to 5 mm, there was mild to moderate narrowing of both exit foramina, there was minimal fluid in the left facet joint, there was mild bilateral post facet arthropathy, unchanged from the prior exam of 2012. The patient, per the most recent examination, had low back pain and right buttock pain and radiating left lower extremity pain into the calf and foot. The patient described a twitching and cramp at night in the lower extremities. It was indicated the patient underwent 2 lumbar injections, the first was of benefit but the second was not. The patient had significant complaints of low back pain and claudicatory symptoms. The patient was unable to walk any significant distance without claudicating. The patient had to lean on a grocery cart in the store and at times was noted to bend over and squat in the store just to complete his shopping. The seating position

was comfortable. Prolonged standing or standing in line was excruciating. The patient had pain with coughing, lifting, and lying in bed and sneezing. The physical examination revealed the patient had moderate paraspinous muscle spasms. The patient's range of motion was full but uncomfortable. The neurologic examination revealed the right extensor hallucis longus had 4/5. The sensory examination was noted to be normal in all dermatomes tested without dermatomal or nondermatomal loss. The deep tendon reflexes on the bilateral patella were 0 and bilateral Achilles was 0. The straight leg raise, supine straight leg raise, and cross leg raise were negative. The impression was the patient had a disc bulge at L3-4. The patient had symptomatic degenerative spondylolisthesis and would be a surgical candidate for L2-3 and L3-4 with a fusion at L2-3 and perhaps L3-4. The patient was a nonsmoker. Diagnoses were noted to be spinal stenosis at L2-3 and L3-4, degenerative slip at L2-3, and a disc bulge at L3-4. The request was for a L2-3, L3-4 decompression/fusion

IMR ISSUES, DECISIONS AND RATIONALES

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

L2-3, L3-4 decompression/fusion: Overturned

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 306-307.

Decision rationale: The Physician Reviewer's decision rationale: ACOEM Guidelines indicate that surgery is considered when serious spinal pathology or nerve root dysfunction is not responsive to conservative treatment. Disc herniation may impinge on a nerve root causing irritation, back and leg symptoms, and nerve root dysfunction and the presence of a herniated disc on an imaging study does not necessarily imply nerve root dysfunction. They further indicate that direct methods of nerve root decompression include laminotomy, standard discectomy and laminectomy and a spinal fusion is indicated in patients with increased spinal instability after surgical decompression at the level of degenerative spondylolisthesis. There was a lack of criterion for performance of the surgical procedure. As such, secondary guidelines were sought. Official Disability Guidelines state that the indications for discectomy/laminectomy include findings of symptoms and objective findings of radiculopathy. There should be findings of L3 and L4 nerve root compression to support the requested surgery. There should be imaging studies which include findings of nerve root compression, lateral disc rupture, or lateral recess stenosis. There should be conservative treatment including activity modification, drug therapy with epidural steroid injection, and physical therapy. The clinical documentation submitted for review indicated the patient had complaints of claudication. The patient had a straight leg raise, cross leg raise, and reflex examination and the reflex examination revealed 0 reflexes on the patellar and the Achilles. The patient had unilateral weakness in the right extensor hallucis longus, and had complaints of low back pain and right buttock pain as well as radiating left lower extremity pain into the calf and foot. The patient had narrowing of both lateral recesses at L2-3. The patient had severe canal stenosis and moderate to severe left and mild right exit foramen narrowing at L2-3 and had moderate to severe canal stenosis on L3-4. The patient had activity

modification as well as epidural steroid injections and physical therapy. The exceptional factors for this review include the patient has claudicatory symptoms indicating the patient cannot walk any significant distance without claudicating. At times the patient would have to bend over and squat in the store to complete shopping and lean on a grocery cart in the store. Additionally, the patient indicated the seating position was most comfortable. The request for the L2-3 and L3-4 decompression would be supported. ACOEM guidelines indicate that patients with increased spinal instability after surgical decompression at the level of degenerative spondylolisthesis may be candidates for fusion. While the patient had a minimal slip of Grade I at the level of L3 on L2, the patient had moderate to severe spinal canal stenosis and had signs and symptoms of claudication and the request for a two level decompression is support