

Case Number:	CM13-0039713		
Date Assigned:	12/20/2013	Date of Injury:	08/27/2010
Decision Date:	02/11/2014	UR Denial Date:	10/02/2013
Priority:	Standard	Application Received:	10/08/2013

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 Medicine and is licensed to practice in New Hampshire and New York. 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 51-year-old male date of injury is August 27, 2000 and the patient has chronic back pain and chronic leg pain. The patient's physical exam does not document any specific radicular findings. His exam date September 9, 2013 does not reveal any significant functional deficits. Then exam documents normal muscle strength normal reflexes normal sensation. The patient's main concern is chronic low back pain. Patient had MRI in August 8, 2013. The MRI showed bony fusion of the L2 and L3 vertebral bodies with multiple level degenerative changes in lumbar spine. There was no evidence of significant spinal stenosis, however at L5-S1 there was mild to moderate stenosis of the left neural foramen possibly abutting the left L5 nerve. There was also a 4 mm disc bulge at this level with mild to moderate central stenosis. There is no evidence of instability on the MRI. EMG nerve conduction study from December 31, 2010 shows some denervation in the right L5 distribution. The patient has been diagnosed with lumbar back pain, lumbar degenerative disc condition, and lumbosacral spinal stenosis.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral L3-L4 Laminectomies: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints
Page(s): s 303-310.

Decision rationale: This patient has not been established criteria for lumbar decompressive surgery. Specifically the patient does not have a documented radiculopathy lower extremity examination at the L3-4 level. Patient has neurophysiologic testing that demonstrated only unilateral L5 denervation. In addition, the physical examination does not actually describe radiculopathy at the L3-L4 nerve roots. MRI imaging study did not show severe spinal stenosis at this level. Criteria for lumbar decompressive surgery at L3-4 not met. There is no specific imaging study that correlates with physical exam findings L3 or L4 radiculopathy and the patient.