

Case Number:	CM13-0044666		
Date Assigned:	12/27/2013	Date of Injury:	07/21/2001
Decision Date:	03/05/2014	UR Denial Date:	10/21/2013
Priority:	Standard	Application Received:	10/31/2013

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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Florida. 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 61-year-old male who reported an injury on 07/21/2001. The mechanism of injury was not provided. The patient was noted to have complaints of chronic low back pain radiating down the left leg with numbness and tingling in the left leg. The patient was noted to have a CT of the lumbar spine without contrast on 10/11/2013 which revealed at the level of L4-5 there was moderate to severe spinal stenosis secondary to a combination of factors including a disc bulge, grade I spondylolisthesis, and marked facet and ligamentum flavum hypertrophy. There was symmetric narrowing of the right neural foramen seen that is likely compressing the exiting right L4 nerve root. The left was noted to be mildly narrowed. At L5-S1, there was noted to be minimal disc bulge. The thecal sac was noted to remain grossly patent. There was marked facet and ligamentum flavum hypertrophy that was seen that there were bilateral foraminal narrowing, greater on the left. The patient was noted on physical examination to have bilateral L4 through S1 stenosis, moderate to severe right greater than left. The patient's diagnoses were noted to be acute back pain with sciatica, and spinal stenosis in the lumbar region without neurogenic claudication. The request was made for a decompressive lumbar laminectomy L4 through S1.

IMR ISSUES, DECISIONS AND RATIONALES

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

Request for decompressive lumbar laminectomy L4, L5, S1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-306, 382-383.. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

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

Decision rationale: ACOEM Guidelines indicate a surgical consultation is appropriate for patients who have severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies including radiculopathy, preferably with accompanying objective signs of neural compromise, activity limitations due to radiating pain for more than 1 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 a failure of conservative treatment to resolve disabling radicular symptoms. The clinical documentation submitted for review indicated the patient had complaints of chronic low back pain radiating down to the left leg with numbness and tingling in the left leg. However, there is a lack of documentation of myotomal or dermatomal findings to support the patient had radiculopathy. It failed to include a thorough objective examination. The patient was noted to have a CT scan which showed moderate to severe spinal stenosis at L4-5. There was a lack of documentation indicating the patient had spinal stenosis at L5-S1. There was a lack of documentation of physical therapy or recent conservative care. It was indicated the patient additionally had not undergone lumbar injections as a form of conservative care. All lower levels of conservative care were not noted to be exhausted. The patient was noted to have undergone a previous lumbar laminectomy approximately 10 years prior to 2013. Given the above and the lack of documentation of exceptional factors to warrant nonadherence to guideline recommendations, the request for decompressive lumbar laminectomy at L4 to S1 is not medically necessary.