

Case Number:	CM13-0049341		
Date Assigned:	12/27/2013	Date of Injury:	07/18/1995
Decision Date:	02/25/2014	UR Denial Date:	10/04/2013
Priority:	Standard	Application Received:	11/07/2013

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, has a subspecialty in Spine Surgery and is licensed to practice in California. 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 63-year-old male who reported an injury on 07/18/1995. The mechanism of injury was not provided. The patient was noted to complain of severe pain radiating down the legs especially with standing and walking with the right much worse than the left. The patient was noted to be unable to walk very far and to have to sit frequently, which, per the physician, it was opined the patient had neurogenic claudication. The pain was noted to radiate below the knee and all the way to the foot. The patient was noted to have most of it anterior and moderate numbness and tingling. The patient was noted to be unable to extend and to walk with a cane and be flexed forward. The patient could not walk far on the toes and heels. The patient was noted to have weakness getting up and taking a step with the right leg. The reflexes and strength were noted to be normal. The patient's MRI showed a congenital narrowing of the canal to cause moderate central canal stenosis with concentric narrowing of the thecal sac to approximately 5 mm in diameter at T12 to L3. The patient was noted to be symptomatic. The impression and diagnoses were noted to be persistent and progressive bilateral neurogenic claudication and lumbar radiculitis secondary to L1 to L3 spinal stenosis and moderate T12-L1 stenosis that was both congenital and acquired. The plan was made to perform a T12 to L3 interlaminar decompression and for the patient to have a 1-day hospital stay.

IMR ISSUES, DECISIONS AND RATIONALES

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

Request for interlaminar decompression of T12-L3: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM.

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

Decision rationale: ACOEM Guidelines indicate that a lumbar surgical consultation is appropriate for patients with severe and disabling lower leg symptoms in a distribution that is consistent with abnormalities on imaging studies, preferably accompanied by objective signs of neural compromise, with activity limitations due to radiating leg pain for more than 1 month or with an extreme progression of lower leg symptoms, with 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 as well as failure of conservative treatment to resolve disabling radicular symptoms. More specific criteria was noted in secondary Guidelines, the Official Disability Guidelines indicate the symptoms and findings which confirm the presence of radiculopathy include objective findings on examination such as straight leg raise test, crossed straight leg raising, and reflex examinations that correlate with symptoms and imaging. Additionally, there should be findings of nerve root compression requiring unilateral hip/thigh/knee pain, imaging studies to correlate radiologic and physical examinations, which include nerve root compression, and an MRI that shows nerve root compression. There should be documentation of conservative treatment that include activity modification, drug therapy requiring NSAIDs, other analgesic therapy, muscle relaxants, or epidural steroid injections and a referral for either physical therapy, manual therapy, or a psychological screening. The clinical documentation indicated the patient had trialed activity modification, physical therapy, aquatic therapy, SCS trial, and medications. The patient was noted to have complaints of severe pain radiating down the legs especially with standing and walking right much worse than left. The patient was noted to be unable to walk more than to the car before he had to sit which was consistent with neurogenic claudication and the patient preferred to flex forward, which was consistent with spinal stenosis. The patient was noted to be status post L3 to L5 lumbar laminectomy and anterior fusion. The patient was noted to have pain radiating below the knee all the way to the foot. The patient was noted to have numbness and tingling. The patient was noted to have findings on MRI of spinal canal stenosis at L1 through L3. At the level of L1-L2, the patient was noted to have congenital narrowing of the central canal, which caused a moderately severe central stenosis with concentric narrowing of the thecal sac of approximately 4 mm in diameter with effacement of much of the CSF space surrounding the nerve roots of the cauda equina. The patient was noted to have failure of conservative treatment. It was indicated that the patient had weakness getting up and taking a step with his right leg. The patient was noted to have neurogenic claudication with pain radiation and difficulty rising from a sitting position to a standing position or walking very

Request for Inpatient stay 1 day at [REDACTED]:
Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Hospital Length of Stay

Decision rationale: The Official Disability Guidelines recommend best practice for inpatient stay for this procedure is 1 day. As the procedure was approved, the request for Inpatient stay 1 day at [REDACTED] is approved and is medically necessary.