

Case Number:	CM13-0052870		
Date Assigned:	12/30/2013	Date of Injury:	07/28/2005
Decision Date:	03/20/2014	UR Denial Date:	10/31/2013
Priority:	Standard	Application Received:	11/18/2013

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 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 58-year-old female who reported injury on 07/28/2005. The patient had an MRI on 07/22/2013 which revealed mild loss of disc height and signal intensity. There was a 3 mm left lateral recess and foraminal extrusion with a superior annular tear which mildly flattened the left anterior lateral thecal sac slightly displacing the left L3 intrathecal nerve root in the left lateral recess and moderately narrowing the proximal left neural foramen which with moderate facet hypertrophy moderately to severely narrowed the left neural foramen impinging the exiting left L2 nerve root with a proximal left neural foramen. At the level L3-4, there was a mild loss of disc signal. There was a 2 to 3 mm disc bulge and moderate facet hypertrophy which mildly narrowed the central canal without obvious nerve root impingement and mild to moderately narrowed the proximal left and mildly narrowed the proximal right neural foramen. At L4-5, there was a mild loss of disc signal. There was a 3 mm degenerative anterior spondylolisthesis of L4 with respect to L5. There was no bulging of the annulus. There was a right foraminal partial tear. There is moderate right and mild to moderate left facet hypertrophy. These findings minimally narrow the neural foramina without nerve root impingement. No canal or lateral recess stenosis. At L5-S1, there was a severe loss of disc height and signal intensity. There was a 4 to 5 mm lateral greater than central diffuse bulging of the annulus with diffuse osteophytic ridging in combination with loss of disc height and facet hypertrophy moderate to severely narrowing the left neural foramen without obvious nerve root impingement and mild to moderately narrowing the right neural foramen without nerve root impingement. The impression was noted to be the patient had grade 1 degenerative spondylolisthesis at L4-5 and mild disc space collapse L3-4 and moderate disc space collapse at L5-S1. Patient had an EMG/NCV on 10/10/2013 which revealed multilevel lumbosacral spine disease with multiple areas of bilateral neural foraminal encroachment and electrodiagnostic evidence for old or chronic bilateral L4-5

radicular injury but no definite acute or ongoing lumbosacral radiculopathy. Additionally, it was noted there were significant psychiatric issues that were deferred to the patient's psychiatrist. Most recent physical examination revealed the patient was ambulating with a limp on the left due to a boot and a cane. The lower extremity and the right EHL was 4/5 and the left EHL +4/5. The patient had a positive straight leg raise bilaterally seated at 90 degrees. There was diminished sensation throughout the left lower extremity. Patellar reflexes were +2 and equal bilaterally. Achilles reflexes were absent bilaterally. There was tenderness in the lumbar midline from L4 to the sacrum and over the bilateral buttocks to palpation. The patient was noted to remain highly symptomatic with back and lower extremity complaints unrelieved by conservative care thus far. The diagnoses were noted to include left lateral disc bulge at L2-3, bilateral foraminal narrowing and moderate central canal stenosis at L3-4, bilateral foraminal narrowing at L4-5, left paracentral disc bulge at L5-S1 with bilateral foraminal narrowing, grade 1 degenerative spondylolisthesis at L4-5 and old or chronic bilateral L4-5 radicular injury. The request was made for a decompression lumbar laminectomy possible fusion at L3, L4, and L5, a 2 to 3 day stay, assistant surgeon, preoperative medical clearance to include labs, chest x-ray and EKG, and a lumbar corset.

IMR ISSUES, DECISIONS AND RATIONALES

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

Decompression and lumbar laminectomy/possible fusion at L3-L5 with Baxano: Upheld

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

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

Decision rationale: ACOEM Guidelines indicate there should be surgical considerations when serious spinal pathology or nerve root dysfunction is not responsive to conservative therapy and direct methods or nerve root decompression include laminotomy standard discectomy and laminectomy. A surgical consultation is indicated for patients who have severe and disabling lower leg symptoms and a distribution consistent with abnormalities on imaging studies (radiculopathy preferably with accompanying objective signs of neural compromise, activity limitations due to radiating leg 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 patient had mild narrowing of the central canal without obvious nerve root impingement at the level of L3-4, there was a lack of indication of moderate to severe spinal canal stenosis at the level of L3-L4. The request for a laminectomy would not be supported at all of the levels requested. ACOEM Guidelines indicate that spinal fusion is appropriate in patients with increased spinal instability after surgical decompression at the level of degenerative spondylolisthesis. The patient was noted to have a grade 1 spondylolisthesis at the level of L4-5. The patient was noted to have mild disc space collapse at L2-3 and L3-4 and moderate disc space collapse at L5-S1. There was a lack of documentation supporting the necessity for the requested fusion. Given the above, the request for

a decompression lumbar laminectomy with possible fusion at L3, L4, and L5 with Baxano is not medically necessary.

A two or three day inpatient hospital stay: Upheld

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

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.

Assistant surgeon: Upheld

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

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.

Preoperative medical clearance: Upheld

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

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.

Lumbar corset: Upheld

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

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.