MAXIMUS Federal Services

Case Number:	CM13-0066134		
Date Assigned:	01/03/2014	Date of Injury:	08/27/2010
Decision Date:	08/04/2014	UR Denial Date:	12/04/2013
Priority:	Standard	Application Received:	12/16/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Orthopedic Surgery, and is licensed to practice in 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 expert 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 injured worker is a 52-year-old male who reported injury on 8/27/10. The mechanism of injury was not provided. The prior treatments included physical therapy and epidural steroid injections. The injured worker underwent an MRI of the lumbar spine without contrast on 8/8/13 which revealed at the level of L3-4 there was a shallow broad based posterior disc bulge, severe bilateral facet osteoarthritis, and moderate hypertrophy of the ligamentum flavum resulting in moderate central spinal stenosis without significant stenosis of the recesses and mild stenosis of the neural foramina bilaterally. It was indicated there were bony fusions of the L2 and L3 vertebral bodies. The physical examination dated 10/21/13 revealed the injured worker had an electrodiagnostic consultation on 12/30/10 which showed a normal nerve conduction study with no evidence of peripheral neuropathy at any level of the bilateral lower extremities and an abnormal EMG with chronic right L5 denervation, which was clinical radiculopathy by diagnostic criteria. The documentation indicated there were no identifiable reflexes in the right lower extremity in the Achilles reflex or common patellar tendon. The left side reflexes were barely findable at the patella and the injured worker had no Achilles reflex. The straight leg raise was equivocal. The diagnoses included spondylosis of unspecified site without myelopathy, spondylolysis in the lumbosacral region, and a Schmorl's node of the lumbar region. The treatment plan included bilateral L3-4 laminectomies based on positive MRI findings and electrodiagnostic studies.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral L3 laminectomies, medial fecectomies, possible fusion/instrumentation by Dr. Timothy Wiebel: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307.

Decision rationale: The ACOEM Guidelines recommend surgical consultations for injured workers who have severe disabling lower leg symptoms in a distribution consistent with abnormalities on imaging, preferably with accompanying objective signs of neural compromise. There should be documentation of activity limitations due to radiating leg pain for more than one month or the extreme progression of lower leg symptoms. There should be 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 documentation of a failure of conservative treatment. The clinical documentation submitted for review indicated the injured worker had a bony fusion of L2-3 vertebral bodies. The injured worker had objective findings upon physical examination. While the physician documented there was support for the electrodiagnostic consultation, the electrodiagnostic consultation was not submitted for review. The physician report there was an abnormal EMG with chronic right L5 denervation and clinical radiculopathy. The level of L3 was not addressed. The EMG/NCV was not provided for review. There was a lack of documentation of failure of conservative care. Given the above, the request is not medically necessary.