Case Number:	CM14-0188968		
Date Assigned:	11/19/2014	**Date of Injury:**	12/27/2011
Decision Date:	01/07/2015	**UR Denial Date:**	10/23/2014
Priority:	Standard	**Application Received:**	11/12/2014

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 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 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 57-year-old male who reported an injury on 12/27/2011 due to being struck on the passenger side by another big rig that did not slow down or stop at an intersection. The injured worker's truck was pushed sideways and slammed into an embankment. Diagnosis was L1-2 and L2-3 spondylostenosis with bilateral lower extremity neurogenic claudication. Past treatment included physical therapy, acupuncture, epidural steroid injection, and on 01/13/2014, surgical intervention at the L4-5 left decompressive hemilaminotomy with radical nerve root decompression. The injured worker had an MRI on 09/19/2014 that revealed moderate to severe central stenosis at the L1-2 and L2-3 secondary to multifactorial acquired degenerative changes. Severe left L4-5 foraminal stenosis, and facet arthropathy and diffuse degenerative changes. Examination revealed reflexes absent at knee jerks and absent at the ankle jerks. Strength is with preserved proximal and distal strength, 5/5 iliopsoas, quadriceps, hamstrings, EHL, anterior tibialis, and gastrocnemius groups. Straight leg raising is negative. Patrick's testing is negative. It was reported that the provider recommends a 2 level decompressive laminectomy. The rationale and request for authorization was not submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

L1-2 and L2-3 Decompression Laminectomy: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307,Chronic Pain Treatment Guidelines Low Back Complaints.

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

Decision rationale: The CAMTUS/ACOEM states that there should be severe and disabling lower leg symptoms in 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 one month or extreme progression of lower leg symptoms; and 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 failure of conservative treatment to resolve disabling radicular symptoms. Although surgery appears to speed short to mid-term recovery, surgical morbidity and complications must be considered. Surgery benefits fewer than 40% of patients with questionable physiologic findings. Moreover, surgery increases the need for future surgical procedures with higher complication rates. In good surgery centers, the overall incidence of complications from first time disk surgery is less than 1%. However, for older patients and repeat procedures, the rate of complications is dramatically higher. Patients with comorbid conditions, such as cardiac or respiratory disease, diabetes, or mental illness, may be poor candidates for surgery. Comorbidity should be weighed and discussed carefully with the patient. Following surgery, exercise is much better than manipulation for rehabilitation treatment to resolve the symptoms. Direct methods of nerve root decompression include laminotomy, standard diskectomy, and laminectomy. Chemonucleolysis with chymopapain is an example of an indirect method. Indirect chemical methods are less efficacious and have rare but serious complications (e.g., anaphylaxis, arachnoiditis). Percutaneous diskectomy is not recommended because proof of its effectiveness has not been demonstrated. Recent studies of chemonucleolysis have shown it to be more effective than placebo, and it is less invasive, but less effective, than surgical diskectomy; however, few providers are experienced in this procedure because it is not widely used anymore. Surgical diskectomy for carefully selected patients with nerve root compression due to lumbar disk prolapse provides faster relief from the acute attack than conservative management; but any positive or negative effects on the lifetime natural history of the underlying disk disease are still unclear. Given the extremely low level of evidence available for artificial disk replacement or percutaneous endoscopic laser diskectomy (PELD), it is recommended that these procedures be regarded as experimental at this time. There was no documentation providing evidence of failure for conservative care. There was no documentation providing objective signs of neural compromise or failure of conservative treatment. There were no other significant factors provided to justify the request for L1-2 and L2-3 decompression laminectomy. Therefore, this request is not medically necessary.

1 day inpatient stay: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307. Decision based on Non-MTUS Citation ODG, Low Back Chapter

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: As the requested surgical intervention is not supported by the documentation, the requested ancillary service is also not supported.