

Case Number:	CM15-0141491		
Date Assigned:	07/31/2015	Date of Injury:	04/25/2014
Decision Date:	08/31/2015	UR Denial Date:	06/18/2015
Priority:	Standard	Application Received:	07/21/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: Illinois, California, Texas
 Certification(s)/Specialty: Orthopedic Surgery

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This injured worker is a 57-year-old male who sustained an industrial injury on 4/25/14. Injury occurred while he was working in an attic, twisting, when he slipped through a hole twisting his back. Conservative treatment included activity modification, medications, physical therapy, and injections. The 6/24/14 lumbar spine MRI impression documented extensive degenerative disc disease superimposed on congenitally small central canal. There was a "mass" below the L4/5 central disc, likely a disc extrusion or disc fragment and less likely differential considerations would include soft tissue mass. There as moderate central canal narrowing at L1/2 and severe central canal narrowing at the L2/3 through L5/S1 disc spaces, and multilevel foraminal narrowing to a lesser degree. The 1/23/15 lumbar spine MRI documented a right subarticular extrusion at L1/2 resulting in right lateral recess stenosis with impingement on the right L2 nerve root, mild central canal stenosis, and mild facet degenerative joint disease. At L2/3, there was mild facet degenerative joint disease, mild central canal stenosis, and severe attenuation of the thecal sac with minor bilateral neuroforaminal narrowing. At L3/4, there was mild facet joint degenerative joint disease, moderately severe central canal stenosis with severe attenuation of the thecal sac with severe left lateral recess stenosis and left L4 nerve root compression. At L4/5, there was mild retrolisthesis, 3 mm central herniation extending caudally, moderately severe central canal stenosis and severe bilateral recess stenosis, and mild bilateral neuroforaminal stenosis. At L5/S1, there was mild to moderate central canal stenosis, moderate bilateral recess stenosis, and moderate bilateral neuroforaminal narrowing. The 6/14/15 treating physician report indicated that the injured worker was last seen on 1/21/15. Primary complaints included low

back pain radiating to the front of both thighs and down the right leg. There was numbness in the left leg, but no pain. He was managing symptoms with Norco, gabapentin and pain patches. He had a lumbar epidural steroid injection that reduced his symptoms 30% for one week. Once he resumed activity, the pain returned. He complained that he felt like he lost power in his legs when he gets up. Physical exam documented 4/5 right quadriceps weakness, and decreased left medial leg sensation. The diagnosis was lumbar stenosis and degenerative disc disease. The injured worker had no last benefit from non-operative treatment and would like to proceed with surgery. Imaging from 2014 showed an L4/5 caudally extruded disc fragment and lumbar stenosis, likely congenital. Given the severe stenosis at L2/3, laminectomy was recommended from L2-S1 with L4/5 discectomy. Repeat MRI was recommended to see if there had been any resolution of the disc herniation prior to surgery. Authorization was requested on 6/9/15 for bilateral lumbar laminectomy L2-S1, possible L4/5 and L5/S1 discectomy. The 6/18/14 utilization review non-certified the request for bilateral lumbar laminectomy L2-S1, and possible L4/5 and L5/S1 discectomy as the clinical exam did not correlate with imaging studies, and there was a significant discrepancy in interpretation of the MRI between the requesting surgeon and radiologist. A subsequent treating physician addendum note documented review of the 1/23/15 lumbar spine MRI showing that the L4/5 disc herniation had resolved. There was moderate central stenosis at L2/3 and L5/S1, severe central stenosis at L3/4 and L4/5, left greater than right, and a paracentral disc bulge at L3/4 with possible extrusion. The revised treatment plan recommended L2-S1 laminectomy and decompression with possible L3/4 discectomy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral lumbar laminectomy L2-S1, possible L4-5 and S1 discectomy: Overturned

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-304. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic: Discectomy/Laminectomy.

Decision rationale: The California MTUS recommend surgical consideration when there is severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies (radiculopathy), preferably with accompanying objective signs of neural compromise. Guidelines require clear clinical, imaging and electrophysiologic evidence of a lesion that has been shown to benefit both in the short-term and long-term from surgical repair. The guidelines recommend that clinicians consider referral for psychological screening to improve surgical outcomes. The Official Disability Guidelines recommend criteria for lumbar discectomy and laminectomy that include symptoms/findings that confirm the presence of radiculopathy and correlate with clinical exam and imaging findings. Guideline criteria include evidence of nerve root compression, imaging findings of nerve root compression, lateral disc rupture, or lateral recess stenosis, and completion of comprehensive conservative treatment. Guideline criteria have been met. This injured worker presents with persistent function-limiting low back pain radiating to both thighs and the right leg with numbness into the left leg.

Clinical exam findings were consistent with updated imaging evidence of nerve root compression and multilevel stenosis. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. Therefore, this request is medically necessary.