

Case Number:	CM15-0189350		
Date Assigned:	10/01/2015	Date of Injury:	01/30/2012
Decision Date:	11/13/2015	UR Denial Date:	08/27/2015
Priority:	Standard	Application Received:	09/25/2015

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: Minnesota, Florida

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:

The injured worker is a 28 year old female, who sustained an industrial-work injury on 1-30-12. She reported initial complaints of back and bilateral knee pain. The injured worker was diagnosed as having lumbosacral disc injury, lumbosacral radiculopathy, bilateral knee pain, lumbosacral sprain-strain, chondromalacia of the patella of both knees. Treatment to date has included medication and home exercises. MRI results were reported on 7-10-15 of the lumbar spine revealed L4-5 a large annular defect with a 7 mm central disc protrusion compressing the thecal sac and the origin of the L5 nerve roots bilaterally, moderate central canal stenosis, at L2-3, there is a 4 mm left paracentral and posterolateral disc protrusion effacing the thecal sac and origin of the left L3 nerve root, at L3-4 there is disc desiccation and right paracentral disc protrusion with mild caudal migration. Currently, the injured worker complains of continued low back pain rated 6 out of 10 with left lower extremity pain of 7 out of 10 and right lower extremity pain of 4 out of 10. Medication included Norco. Per the primary physician's progress report (PR-2) on 8-10-15, exam noted slightly antalgic gait, moderately obese, lumbosacral tenderness to palpation with myofascial tightness and facet tenderness bilaterally from L3-5, right greater than left. Pain is aggravated with facet loading, normal strength. The knees have positive tenderness to palpation, left greater than right, pain with range of motion, with more pain on the medial aspect. Current plan of care includes medication and surgery. The Request for Authorization requested service to include Left L2-L3 decompression. The Utilization Review on 8-27-15 approved surgery at L3-4 and L4-5 levels but denied the request for Left L2-

L3 decompression, per CA MTUS (California Medical Treatment Utilization Schedule) Guidelines; Low Back Complaints 2004.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left L2-L3 decompression: Overturned

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Surgical Considerations.

Decision rationale: The injured worker is a 28-year-old female with a date of injury of 2009. She complains of low back pain with radiation down the left lower extremity to the knee. She has been diagnosed with lumbar radiculopathy as well as chondromalacia of the left knee. There was suspicion of patellofemoral syndrome and she was treated with physical therapy. She underwent an MRI scan of the lumbar spine on May 4, 2012 which revealed spinal stenosis due to short pedicles and protrusions of the intervertebral disks at multiple levels. Physical therapy and chiropractic treatment was not of particular benefit. Epidural steroid injections were helpful but the benefit was not lasting. EMG and nerve conduction studies of November 2013 were normal. Per QME of 5/18/2015 examination of the lumbar spine revealed tenderness to palpation over the lower lumbar paraspinal muscles from L3-L5. Straight leg raising was negative bilaterally. The deep tendon reflexes were mildly reduced, rated 1+ in the left knee and 2+ in the right knee. The Achilles reflexes were 2+ bilaterally. The diagnosis was chronic low back pain with suspected left lumbar radiculopathy with MRI of the lumbar spine revealing multilevel disc bulges with mild to moderate central and left-sided disc protrusions. The diagnosis with regard to the knees was chondromalacia with lateral patellar tilt and subluxation bilaterally. The MRI scan of the lumbar spine was repeated on 7/10/2015. This revealed at L4-5 there was a large annular defect with a 7 mm central disc protrusion compressing the thecal sac and the origin of the L5 nerve roots bilaterally. There was moderate central canal stenosis. At L2-3 there was a 4 mm left paracentral and posterior lateral disc protrusion effacing the thecal sac and the origin of the left L3 nerve root. At L3-4 there was disc desiccation and a right paracentral disc protrusion with mild caudal migration. There was effacement of the thecal sac and the origin of the L4 nerve roots. There was marginal osseous ridging with minimal right foraminal narrowing. On 8/26/2015 a utilization review noncertified the request for left L2-3 decompression but certified the remaining requests for bilateral L3-4 and bilateral L4-5 decompression. The California MTUS guidelines indicate surgical considerations for 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. The injured worker has evidence of a herniation at L2-3 measuring 4 mm and located to the left of the midline with associated pain in the left thigh going down to the knee and diminished knee jerk on the left side. She is undergoing decompressive surgeries at L3-4 and L4-5. On the basis of the clinical findings as well as MRI findings it would be appropriate to address the herniation at L2-3 at the same time. As such, the request for L2-3 decompression on the left is supported and the medical necessity of the request has been substantiated. Therefore is medically necessary.