

Case Number:	CM15-0216183		
Date Assigned:	11/05/2015	Date of Injury:	06/21/2011
Decision Date:	12/28/2015	UR Denial Date:	10/12/2015
Priority:	Standard	Application Received:	11/03/2015

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 58 year old male, who sustained an industrial injury on June 21, 2011. The injured worker was currently diagnosed as having chronic low back pain and chronic left lumbar radiculitis secondary to lateral recess stenosis at L4-5 greater than L3-4. Treatment to date has included diagnostic studies, injections and medication. On October 5, 2015, the injured worker complained of persistent back and radiating leg pain. The pain was reported to be worse with sitting, standing and walking. He was reported to have two epidural steroid injections with each one lasting three months and indicating intraspinal pathology. An MRI scan showed mild spondylosis at L3-4 and L4-5, no significant herniated disc or neural foraminal encroachment and moderate bilateral lateral recess stenosis at L3-4 and L4-5. Physical examination revealed mild left sacroiliac joint tenderness and mild straight leg raising on the left. The treatment plan included L3 to L5 interlaminar decompression without discectomy or fusion. On October 12, 2015, utilization review denied a request for left L3-L5 interlaminar decompression without discectomy or fusion.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left L3-L5 interlaminar decompression without discectomy or fusion: Upheld

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

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

Decision rationale: The injured worker is a 58-year-old male with a date of injury of 6/21/2011. He complains of low back and left leg pain. Per available documentation, the MRI of the lumbar spine dated 6/18/2014 revealed at L2-3 there was mild to moderate annular disc bulging/endplate spurring contributing to mild to moderate left-sided and very mild right-sided foraminal narrowing. At L3-4 there was minimal degenerative retrolisthesis with mild posterior bulge and suspected subtle central and right paracentral annular tear. There was mild to moderate right-sided and mild left sided facet osteoarthritis contributing to a mild to moderate central stenosis. There was no significant lateral recess encroachment and only minimal foraminal narrowing bilaterally. At L4-5 there was mild central disc bulging with is suspected central/left paracentral annular tear. Moderate to marked right-sided and mild to moderate left sided facet osteoarthritis and possibly an element of borderline congenital narrowing of the central canal contributed to a mild central stenosis. There was minimal right lateral recess encroachment and no left lateral recess encroachment. There was moderate right-sided and mild to moderate left-sided foraminal narrowing. At L5-S1 there was a suspected small central and right paracentral contained herniation minimally encroaching upon the right lateral recess and no significant central stenosis. Disc bulging versus protrusion partially overlapped the inner neural foramen on the right combining with moderate right sided facet osteoarthritis to cause mild to moderate right-sided foraminal narrowing. There was no significant left recess lateral encroachment or left-sided foraminal narrowing. The progress notes dated October 5, 2015 document low back and chronic left leg pain for 4 years. On examination he was mildly obese and in mild distress. He had mild left SI joint tenderness and mild straight leg raising on the left. He was neurologically intact. The impression was chronic low back pain and chronic left lumbar radiculitis secondary to lateral recess stenosis at L4-5 greater than L3-4. The plan was left L3-L5 interlaminar decompression without discectomy or fusion. California MTUS guidelines indicate surgical considerations for severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies, 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, 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. In this case there is no neurologic deficit documented. EMG and nerve conduction studies have not been submitted and there is no objective evidence of radiculopathy. There is no clear clinical, imaging, and electrophysiologic evidence of the same lesion that has been shown to benefit from surgical intervention. As such, the request for surgery is not supported by guidelines and the medical necessity of the request has not been substantiated.