

Case Number:	CM15-0051084		
Date Assigned:	03/24/2015	Date of Injury:	03/12/2014
Decision Date:	05/07/2015	UR Denial Date:	03/12/2015
Priority:	Standard	Application Received:	03/17/2015

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:

The injured worker is a 47-year-old female who sustained an industrial injury on 3/12/14. Injury occurred when she was knocked over by an airport passenger, and fell on her back with her luggage falling on top of her. Past medical history was positive for current smoking. The 5/23/14 electrodiagnostic studies evidenced acute over chronic left L4/5 radiculopathy. The 11/24/14 spine consult report cited progressive bilateral leg pain, numbness in her legs, difficulty with her footing, increased back pain, abnormal gait, scoliotic list, and intractable pain. Physical exam documented a forward list in a bent manner, and moderate paraspinal spasms. There were absent reflexes at the patella and Achilles level and 5/5 lower extremity strength. Imaging showed L4/5 punctate stenosis causing severe nerve root compression due to a combination of ligamentum flavum intrusion, congenital stenosis, and facet arthropathy. There was moderate L3/4 and moderate to severe L2/3 stenosis. Flexion/extension x-rays suggested hypermobility at L4/5 without gross movement. The diagnosis was severe neurogenic claudication, radiculopathy second to severe stenosis at L4/5 with some degree of hypermobility, as well as L3/4 and L2/3. The injured worker was deemed an ideal operative candidate for surgical decompression at L2/3, L3/4, and L4/5, combined with an intraspinal device at L4/5 to see if this stabilized or ameliorated her symptoms in a dynamic manner. The 1/15/15 lumbar spine CT scan impression documented congenital bony stenosis with superimposed multilevel acquired stenosis from degenerative disc disease and hypertrophic changes of the posterior elements. There was marked central canal stenosis at L4/5 and moderate stenosis at L3/4 and L2/3. There was moderate to marked bilateral foraminal stenosis at L4/5 and moderate foraminal stenosis at L3/4 and L2/3.

The 1/15/15 lumbar spine MRI demonstrated multilevel disc bulging and facet joint hypertrophy from L2 through L5 contributing to moderate/severe central canal stenosis and neuroforaminal stenosis bilaterally with compromise of the nerve roots at L2/3 and L3/4. The 3/12/15 utilization review non-certified the request for bilateral L2/3, L3/4, and L4/5 and intraspinous device at L4/5 based on the absence of detailed comprehensive conservative treatment failure, and no evidence of instability on independent radiographs. Additionally, the request for intraspinous device was non-specific and required clarification as some devices were not supported in the literature. The 4/13/15 appeal letter stated that the injured worker presented with severe central canal stenosis at L2/3, L3/4, and L4/5 with a hint of spondylolisthesis at L4/5. Ambulatory tolerance was ½ block. Physical exam findings included bilateral 4/5 anterior tibialis and extensor hallucis longus weakness. She had exhausted extensive effort at conservative treatment, including physical therapy, chiropractic, massage, acupuncture, etc. Surgery would include multilevel decompression, possibly full laminectomy, and if able to preserve the spinous processes, then consideration of an interspinous placement at L4/5 to give her some stability with neuroforaminal height improvement.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral L2-L3, L3-L4, and L4-L5 surgical decompression and intraspinous device at L4-L5: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 304-306.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Lumbar & Thoracic: Discectomy/Laminectomy; Interspinous decompression device (X-Stop).

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 decompression 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. The ODG do not recommend use of an interspinous device over decompression surgery. FDA approved indications include patients aged 50 or older, who are suffering from neurogenic intermittent claudication secondary to a confirmed diagnosis of lumbar spinal stenosis. Interspinous devices may be implanted at one or two lumbar levels in patients in whom surgical treatment is indicated at no more than 2 levels. Guideline criteria have not been met. This injured worker presents with

intractable low back and bilateral leg pain with signs/symptoms of neurogenic claudication. Clinical exam findings are consistent with imaging evidence of multilevel nerve root compromise and significant spinal stenosis. Reasonable conservative treatment has been tried and has failed to provide sustained improvement. However, the request for use of an interspinous device is not consistent with FDA indications based on the injured worker's age and the documented need for laminectomy at 3 levels. Therefore, this request is not medically necessary.

Preoperative medical clearance: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 304-306.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Institute for Clinical Systems Improvement (ICSI). Preoperative evaluation. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2010 Jun. 40 p.

Decision rationale: As the surgical request is not supported, this request is not medically necessary.