MAXIMUS Federal Services

Case Number:	CM15-0051087		
Date Assigned:	03/24/2015	Date of Injury:	09/24/2012
Decision Date:	05/05/2015	UR Denial Date:	03/13/2015
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: 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 62 year old male who sustained an industrial injury on 9/24/12. The injured worker reported symptoms in the back and left lower extremity. The injured worker was diagnosed as having lumbar radiculopathy, lumbar spinal stenosis, and lumbar spondylosis. Treatments to date have included injections, non-steroidal anti-inflammatory drugs, and physical therapy. Currently, the injured worker complains of back pain with radiation to the left lower extremity. The plan of care was for bilateral decompression at L3-4, L4-5, and L5-S1 with medial facetectomies and a follow up appointment at a later date.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left approach and bilateral L3-4, L4-5 and L5-S1 decompression with medial facetectomies: Upheld

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, 306, 307.

Decision rationale: The injured worker is a 62-year-old male with a date of injury of 9/24/12. He complains of low back pain radiating down the left lower extremity. The low back pain has been present for the last 30 years and the left leg pain for the last 6 years. There is a history of peripheral vascular disease related to smoking. Femoral artery stents were placed in July 2014 and he has been taking Plavix. Neurologic examination has revealed decreased sensation in the left lateral ankle. The left Achilles reflex was absent. EMG and nerve conduction studies of February 13, 2014 revealed a chronic left L5 radiculopathy and possible S1 radiculopathy. MRI scan of the lumbar spine dated 9/16/2013 revealed multilevel lumbar spondylosis, neural foraminal narrowing on the right at L3-4, facet arthropathy more severe on the right at L4-5, and progressive narrowing of the left sided nerve root canal at L5-S1. The MRI scan of the lumbar spine dated 11/5/2014 revealed multiple level lumbar spondylosis. At L3-4 there was neural foraminal narrowing on both sides with the exiting right nerve root compressed. At the L4-5 level there was narrowing of the lateral recess on both sides, the left side more affected than the right but both nerve roots were compressed. There was also central canal stenosis exacerbated by epidural lipomatosis. At L5-S1 level there was facet arthropathy with a broad-based disc bulge and a far left lateral disc herniation. The exiting nerve root was effected far out in the neural foramen. The progress notes from January 9, 2015 documented no improvement in symptoms after bilateral stents. On 2/27/2015, documentation indicates continuing low back pain radiating to the left buttock and down the left lower extremity with weakness and numbness/tingling. There was a history of neurogenic claudication. Examination revealed negative straight leg raising, diminished deep tendon reflexes at the left knee and ankle and minimal weakness of dorsiflexion of the left foot compared to the right. The injured worker has chronic low back and left leg pain. There is a chronic left L5 radiculopathy documented on electromyography and supported by physical examination. The MRI scan corroborates the pathology at L4-5 on the left. However, the clinical examination has not revealed definite evidence of radiculopathy at 3 levels on both sides for which surgery is requested. California MTUS guidelines recommend surgical considerations for patients who have 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 limitation 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. Direct methods of nerve root decompression include laminotomy, standard discectomy, and laminectomy. Spinal stenosis usually results from soft tissue and bony encroachment of the spinal canal and nerve roots. The surgical treatment for spinal stenosis is usually complete laminectomy. Surgery is rarely considered in the first 3 months after onset of symptoms and a decision to proceed with surgery should not be based solely on the results of imaging studies. Some evidence suggests that patients with moderate to severe symptoms may benefit more from surgery than from conservative treatment. The injured worker clearly needs the decompression at L4-5 on the left based upon the clinical examination, MRI, and electrodiagnostic studies. However, the request as stated is for bilateral decompression at L3-4, L4-5, and L5-S1 with medial facetectomies. Although an argument can be made for the requested surgery on the basis of the MRI scan, the clinical and electrodiagnostic findings do not support the request for bilateral decompression at L3-4, L4-5, and L5-S1. The guidelines indicate that the decision to proceed with surgery should not be based solely on the results of the imaging studies. As such, the request for bilateral L3-4, L4-5, and

L5-S1 decompression with medial facetectomies is not supported and therefore the request is not medically necessary.