MAXIMUS Federal Services

Case Number:	CM15-0083533		
Date Assigned:	05/11/2015	Date of Injury:	06/11/1988
Decision Date:	06/08/2015	UR Denial Date:	04/22/2015
Priority:	Standard	Application Received:	04/30/2015

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 66-year-old male who sustained an industrial injury on 6/11/88. Injury occurred while he was pushing a motorcycle off a tow truck. Past surgical history was positive for right L3/4 laminotomy in 1988. Past medical history was positive for insulin-dependent diabetes mellitus and a significant adverse reaction to an epidural steroid injection. The 1/21/15 lumbar spine CT scan with contrast documented discogenic and facet degenerative disc disease at L2/3 causing mild to moderate spinal canal and mild neuroforaminal stenosis with no definite nerve root impingement. There were post-surgical changes at L3/4 with partial right laminectomy. Degenerative and post-surgical facet osteophytes contributed to lateral recess and neuroforaminal narrowing with likely impingement of the bilateral L3 nerve roots and possible impingement of the bilateral L4 nerve roots. At L2/3, there was a mild disc bulge with vacuum disc phenomenon and small endplate osteophytes, causing indentation on the ventral thecal sac. There was ligamentum flavum hypertrophy/redundancy and mild facet arthropathy. There was narrowing of the lateral recesses and crowding of the bilateral L3 nerve roots. There was mild bilateral neuroforaminal narrowing with crowding of the L2 nerve roots. At L4/5, there was no significant disc bulge or protrusion. There were moderate facet degenerative changes with ligamentum flavum hypertrophy/redundancy. The central spinal canal was patent. There was mild to moderate bilateral neuroforaminal stenosis. At L5/S1, there was no significant disc bulge or protrusion. There were moderate to severe bilateral facet degenerative changes with significant facet osteophytes. There was no significant central spinal canal or neuroforaminal narrowing. The 1/26/15 lumbar spine x-ray impression documented lumbar degenerative disc

disease most severe at L3/4 with no dynamic instability demonstrated. There were moderate facet arthropathic changes present at L3/4, L4/5, and L5/S1. The 1/26/15 treating physician report cited low back pain radiating into the bilateral buttocks and occasionally into the left groin. He had continued right leg numbness and progressive bilateral lower extremity weakness and instability. He was now using a motorized wheelchair to get around. Physical exam documented right lower extremity strength as 2/5 hip flexion, 4/5 knee extension and dorsiflexion, and 4+/5 plantar flexion. On the left, strength was 4+/5 globally. He had complete hypoesthesia involving the right leg up to the hip area, and was not even able to feel light touch. Left lower extremity sensation was intact. Gait was very unsteady with a wide based gait and leading with his left leg. Lower extremity deep tendon reflexes were +1 and symmetrical. CT myelogram and x-rays were reviewed. The treating physician report discussed findings of moderate to severe spinal stenosis from L2/3 down to L5 with no evidence of spinal instability. The injured worker's low back pain was likely generated from the spinal and foraminal stenosis, and severe facet arthropathy. The treatment plan recommended lumbar decompression with laminectomies and foraminotomies from L2 to L5. The injured worker was to consider this option. The 4/22/15 utilization review modified the request for L2-L5 laminectomy and 1-2 day inpatient stay and certified L2-L4 laminectomy with a 1 day inpatient stay. The rationale for modification indicated that there was no evidence of significant pathology at L4/5 and physical examination was not specific to this level as a potential source of nerve root impingement. The length of stay was modified to 1 day consistent with Official Disability Guidelines recommendations for laminectomy.

IMR ISSUES, DECISIONS AND RATIONALES

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

L2-L5 laminectomy: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 306. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

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.

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. Guideline criteria have

been met. This patient presents with chronic radicular low back pain and worsening lower extremity weakness and functional loss. Clinical exam evidence documented motor deficit that correlates with reported imaging evidence of moderate to severe L2-L5 spinal stenosis. Evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. Therefore, this request is medically necessary, including at the L4/5 level.

Associated service: 1-2 inpatient stay: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic: Hospital length of stay (LOS).

Decision rationale: The California MTUS does not provide recommendations for hospital length of stay. The Official Disability Guidelines recommend the median length of stay (LOS) based on type of surgery, or best practice target LOS for cases with no complications. The recommended median target for lumbar laminectomy is 2 days, and the best practice target is 1 day. Guideline criteria have been met for inpatient length of stay up to 2 days, based on patient age and significant co-morbidity. Therefore, this request is medically necessary.