

Case Number:	CM14-0166762		
Date Assigned:	10/14/2014	Date of Injury:	02/02/1991
Decision Date:	11/14/2014	UR Denial Date:	10/06/2014
Priority:	Standard	Application Received:	10/09/2014

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. The expert reviewer is Board Certified in Orthopaedic Surgery and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This 72-year-old male operating engineer sustained an industrial injury on 2/2/1991. Injury occurred when a wrench slipped while he was opening a valve causing him to fall. Past medical history was positive for hypercholesterolemia, hypertension, arthritis, diabetes, and obesity. The 12/8/11 lumbar spine MRI documented grade 1 anterolisthesis at the L4/5 with definite spondylosis and degenerative disc disease at L5/S1 with severe right neuroforaminal narrowing. The patient underwent L4/5 and L5/S1 interbody fusion on 5/23/12. The patient underwent bilateral L4/5 and L5/S1 lumbar medial branch blocks on 2/21/14 and 3/10/14. The 8/22/14 lumbar spine MRI impression documented canal, lateral recess and foraminal narrowing at L4/5 with nerve root abutment but no definite impingement. There was posterior disc osteophytic ridging at L4/5 that abutted descending nerve roots within the lateral recess and minimally along the undersurface of the existing nerve root from the left L4/5 foramen but no definite impingement was appreciated at this level. There was a partially extruded interbody fusion device at L5/S1 encroaching the left lateral recess and contributing to left neuroforaminal narrowing. There was abutment and posterior displacement of the descending nerve roots within the left L5/S1 lateral recess by this abnormality. There was posterolateral and far lateral disc osteophytic ridging at L5/S1 that abutted and imprinted the exiting nerve root from the right neural foraminal. The 9/11/14 treating physician report cited severe constant low back and left leg pain, and numbness radiating down the left leg with foot drop. Symptoms were worse with weight bearing, prolonged sitting, and standing. Pain was alleviated by Percocet. Physical exam documented height 66 inches, weight 513 pounds, body mass index 82.8, normal gait and station, normal lower extremity sensation, and symmetrical patella and Achilles reflexes. Neurologic exam was reported as stable. Muscle strength was reported normal with no atrophy. The diagnosis was lumbar degenerative disc disease, spondylolisthesis, spinal stenosis, obesity, and

lumbar herniated nucleus pulposus. The treatment plan recommended laminectomy at L4/5 and L5/S1 with hardware removal. Percocet 10/325 mg #200 was prescribed. The 10/6/14 utilization review denied the lumbar surgery request as the physical exam findings did not identify any motor strength deficits or other neurologic findings to support radiculopathy consistent with the dermatomal or myotomal patterns of L3, L4, L5 or S1 nerve distributions. There was no imaging evidence of definite pathology at the L3/4 level.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 removal of posterior instrumentation with L3-L4, L4-L5 and L5-S1 laminectomy:

Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-306.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 208/209. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic, Hardware implant removal (fixation), Laminectomy/ laminotomy, Discectomy/ laminectomy

Decision rationale: The California MTUS guidelines recommend lumbar decompression surgery with evidence of neurogenic claudication and imaging findings that confirm the nerve roots are compressed consistent with the neurologic symptoms, and there was a lack of responsiveness or unsatisfactory results to adequate conservative treatment over a minimal of 6 to 8 weeks. The Official Disability Guidelines recommend laminectomy for lumbar spinal stenosis. Surgical indications include imaging evidence with concordance between radicular findings on radiologic evaluation and physical exam findings, and conservative treatment. Conservative treatment criteria include activity modification, drug therapy, and referral to physical therapy, manual therapy, psychological screening, or back school. Guidelines do not recommend the routine removal of hardware implanted for fixation, except in the case of broken hardware or persistent pain. Guideline criteria have not been met. There is no current physical exam evidence of a neurologic deficit. There is no imaging evidence of nerve root compression at L3/4 or L4/5. Evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial consistent with guidelines and failure has not been submitted. The medical necessity of laminectomy at L3/4 is not established. Therefore, this request is not medically necessary.