

Case Number:	CM14-0083347		
Date Assigned:	07/21/2014	Date of Injury:	12/14/2011
Decision Date:	10/15/2014	UR Denial Date:	05/21/2014
Priority:	Standard	Application Received:	06/05/2014

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 Orthopedic Surgery and is licensed to practice in Minnesota. 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:

The injured worker is a 56 year old male with a history of low back pain and bilateral lower extremity pain all the way down to the feet. The pain is associated with complaints of numbness in the L5-S1 distribution, tingling, burning, and weakness. The history dates back to 1997 with recurrences over the years. An MRI scan in the year 2007 was said to reveal bulging discs at L3-4, L4-5, and L5-S1. The Radiology report is not included with the records. The worker underwent epidural steroid injections in April 2007 and again in November 2007 with a good response. A third epidural steroid injection was given in May 2010 with a good response. He was also treated with Physical Therapy. Additional musculoskeletal issues involve the right shoulder, right knee, hips and ankles. There is a history of hypothyroidism. The notes indicate a repeat MRI of the lumbar spine on 01/29/2013 with unknown results and EMG and nerve conduction studies on February 4, 2013 which showed evidence of S1 radiculopathy. The EMG and Nerve conduction study report is not included. In July 2013 he received another epidural steroid injection with a good result. A CT scan dated 02/01/2014 is reported to show mild bilateral lateral recess stenosis at L3-4, slight retrolisthesis of L3 on L4, mild central stenosis at L4-5 with bilateral lateral recess stenosis and left neuroforaminal stenosis. A pocket of air along left ventral epidural space / lateral recess of superior L5 is most likely due to a caudally migrated disc. Surgery was approved for bilateral laminectomy and foraminotomy at L5-S1 on 4/24/14. The provider is recommending additional laminectomies and foraminotomies at L4-5 and L3-4 bilaterally. The records mention bilaterally diminished knee jerks and Achilles reflexes but do not document specific objective evidence of L4 or L5 radiculopathy either on Physical exam or on the EMG. Diminished sensation is reported along the L5-S1 dermatome, right greater than left. The documentation indicates high pain levels in the lumbosacral area with diminished range of motion representing more back pain than leg pain. The MRI report pertaining to the suspicious caudally migrated disc fragment at the

superior L5 area seen on the unenhanced CT is not available. The official CT report is also not included.

IMR ISSUES, DECISIONS AND RATIONALES

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

Additional Surgery with Bilateral laminectomy and foraminotomy L3-4 and L4-5 (Lumbar Spine): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305, 306. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Discectomy/Laminectomy, ODG Indications for Surgery, Discectomy/Laminectomy

Decision rationale: The available records include adequate objective evidence for necessitating surgery at the L5-S1 level. However, the Radiology reports pertaining to the imaging studies and the EMG report have not been provided. The neurological finding supporting laminectomy and foraminotomy at L4-5 and L3-4 is said to be bilateral hyporeflexia (1/4) involving the knee jerks and Achilles reflexes in both lower extremities but no other objective basis for radiculopathy at these levels such as dermatomal sensory or motor changes is presented. The CA MTUS guidelines include severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies (radiculopathy), preferably with accompanying objective signs of neural compromise. Clear clinical, imaging, and electrophysiologic evidence of a lesion that has been shown to benefit in both short and long term from surgical repair at these two additional levels has not been provided. Surgery benefits fewer than 40 percent of patients with questionable physiologic findings. Moreover surgery increases the need for future surgical procedures with higher complication rates. The ODG guidelines for confirmation of L4 and L5 radiculopathy have not been documented in the clinical records. Therefore the requested additional surgical procedures of laminectomy and foraminotomy at L3-4 and L4-5 are deemed not medically necessary.