



Case Number:	CM15-0111993		
Date Assigned:	06/18/2015	Date of Injury:	06/06/2012
Decision Date:	07/21/2015	UR Denial Date:	05/29/2015
Priority:	Standard	Application Received:	06/10/2015

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 59-year-old female who sustained an industrial injury on 6/06/12. Injury occurred while she was working as a nurse and attempting to restrain a combative patient. Past medical history was positive for elevated cholesterol and cervical radiculopathy. The 5/22/14 lumbar spine MRI impression documented mild diffuse disc bulge with moderate degenerative facet hypertrophy and mild ligamentum flavum thickening in conjunction with epidural lipomatosis and developmentally short pedicles resulting in moderate canal stenosis and mild bilateral foraminal narrowing at L1/2 and L2/3. There was moderate diffuse disc bulge at L3/4 with moderate to advanced degenerative facet hypertrophy and moderate ligamentum flavum thickening in conjunction with epidural lipomatosis and developmentally short pedicles resulting in moderate canal stenosis and mild to moderate bilateral foraminal narrowing displacing the right L3 nerve root. At L4/5, there was moderate diffuse disc bulge with mild to moderate degenerative facet hypertrophy with evidence of mild canal narrowing and no definitive transversing nerve root impingement with evidence of moderate to severe right foraminal stenosis likely impinging on the exiting right L4 nerve root. At L5/S1, there was mild diffuse disc bulge with moderate degenerative facet hypertrophy, left greater than right, with no significant canal stenosis and moderate bilateral foraminal stenosis. The 3/4/15 orthopedic agreed medical examiner report cited low back pain radiating through the right lower extremity to the knee with associated numbness and tingling. Symptoms increase with twisting, stooping, bending, coughing, sneezing, pushing, pulling, and straining with bowel movements. She denied any bowel/sexual dysfunction or bladder incontinence. Symptoms were increased with standing

or walking for 2 to 3 minutes and sitting for 40 minutes. Difficulty was reported with activities of daily living. Physical exam documented height 5'7", weight 341 pounds, and moderate difficulty changing positions between sitting, standing, and supine postures. There was lower lumbar tenderness to palpation and muscle spasms. Range of motion was limited and guarded. There was normal lower extremity motor strength and reflexes, and diminished sensation on the right. Straight leg raise was positive on the right. The diagnosis was status post acute lumbosacral sprain/strain and contusion, and industrial aggravation of degenerative lumbar spondylosis with multilevel stenosis. The injured worker was felt to be permanent and stationary. The AME opined that the injured worker's weight was a significant impediment with respect to safely performing surgery and multilevel degenerative disc disease did not traditionally lend itself favorably to surgical treatment. Future medication recommendations included conservative treatment. The 4/20/15 right lower extremity electrodiagnostic study was reported as normal. The 5/14/15 spine surgery request indicated that the injured worker was a candidate for L1 through L5 laminectomy due to persistent pain, weakness, numbness, and claudication, as well as impairment of bowel and bladder function. Authorization was requested for lumbar laminectomy at the L1/2, L2/3, L3/4, and L4/5 levels. The 5/18/15 the treating physician report cited bilateral lumbosacral pain radiating into the right buttock and lateral thigh with intermittent numbness and tingling. The injured worker had begun aqua therapy and attended 2 visits but got the flu and was rescheduled to restart soon. Medications continued to work well. She was requesting a gastric bypass and breast reduction. She had completed 4 visits of acupuncture with 50% decrease in pain. Prior lumbar epidural steroid injections were ineffective. She was to follow-up with the spine surgeon and continue medications and aqua therapy. The 5/29/15 utilization review non-certified the request for lumbar laminectomy from L1/2 to L4/5 as there was documentation that the injured worker was morbidly obese with could be contributing to the symptomatology and carried risk of surgical complication, and a lack of thorough exam confirming complaints of bowel/bladder dysfunction.

IMR ISSUES, DECISIONS AND RATIONALES

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

One lumbar laminectomy at L1-L2, L2-L3, L3-L4 and L4-L5 levels: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

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

discectomy 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. Guidelines indicate that there is an increased risk of post-operative complications for obese patients, but a BMI of 25 or more was not associated with a greater risk of mortality. Guideline criteria have not been met. This injured worker presents with low back pain radiating down the lateral right leg to the knee with intermittent numbness and tingling. There is imaging evidence of multilevel disc bulging and plausible nerve root impingement. However, there is no detailed discussion of bowel/bladder dysfunction or clear dermatomal distribution of sensory loss. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. AME caution was documented regarding the increased surgical risk factors due to BMI greater than 50. Therefore, this request is not medically necessary at this time.