

Case Number:	CM15-0062070		
Date Assigned:	04/08/2015	Date of Injury:	02/03/2014
Decision Date:	05/18/2015	UR Denial Date:	03/12/2015
Priority:	Standard	Application Received:	04/01/2015

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 51-year-old male who sustained an industrial injury on 2/3/14, relative to lifting heavy boards. Conservative treatment included multiple epidural steroid injections, physical therapy, chiropractic, activity modification, and medications. Records documented the 4/24/14 lumbar spine MRI demonstrated mild to moderate degenerative disc disease at L4/5 and L5/S1. There was a 3 mm disc bulge at L4/5 effacing the anterior thecal sac with mild facet arthropathy, central canal stenosis, and foraminal narrowing bilaterally. There was a 3 mm disc protrusion at L5/S1 effacing the anterior thecal sac with moderate facet arthropathy contributing to more severe left and mild right foraminal narrowing. The 3/5/15 treating physician report cited continued low back pain radiating to the lower extremity, left greater than right, with numbness. Physical exam documented lumbar paraspinal tenderness with loss of range of motion and decreased left L5/S1 sensation. There was no motor weakness. Authorization was requested for decompression with a partial facetectomy at L4/5 and L5/S1 with insertion of a paradigm device. The 3/12/15 utilization review indicated that guideline criteria had been met to allow partial certification of the partial facetectomy and decompression at L4/5 and L5/S1. The use of the paradigm device was not supported by guidelines and the lack of indications in the imaging studies regarding any instability that would require stabilization.

IMR ISSUES, DECISIONS AND RATIONALES

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

Decompression with partial facetectomy and insertion of paradigm device at L4-5 and L5-S1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 304-306. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)-low back chapter.

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 i½ Lumbar & Thoracic, Discectomy/Laminectomy; Interspinous spacer device.

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 electro-physiologic 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. The California MTUS guidelines do not provide recommendations relative to the paradigm devices. The Official Disability Guidelines do not recommend the use of interspinous spacer devices over decompression surgery, because the failure rate is much higher. Guideline criteria have not been met. This patient presents with function-limiting low back pain radiating into the lower extremities with numbness. Clinical exam findings are consistent with imaging evidence of plausible nerve root compression at L5/S1. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. The 3/12/15 utilization review partially certified this request for decompression surgery at L4/5 and L5/S1 without the paradigm device. There is no guideline support for the use of the interspinous spacer device over decompression surgery. There is no compelling rationale for use of this device to warrant an exception to guidelines. Therefore, this request is not medically necessary.