

Case Number:	CM15-0092620		
Date Assigned:	05/19/2015	Date of Injury:	01/10/2013
Decision Date:	10/06/2015	UR Denial Date:	05/04/2015
Priority:	Standard	Application Received:	05/13/2015

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: Minnesota, Florida
 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 injury on 1-10-13 resulting when lifting a case of sodas from two feet off the ground and feeling a sharp pain in the low back. Diagnostic tests include MRI on 3-4-13, and electromyogram nerve conduction studies lower extremities. Diagnoses include L4-S1 disc degeneration; Left L4-5 mild lateral recess stenosis; L4-S1 facet arthropathy; Left leg radiculopathy vs. pseudo radiculopathy due to facet arthropathy and chronic lumbago. Treatment included physical therapy, TENS unit, exercise and hot therapy. The PR2 orthopedic examination dated 4-15-15 reports the IW has ongoing predominantly left sided low back pain that radiates down the left buttocks and posterior thigh and occasionally into the calf; intermittent right anterior thigh numbness; and right foot tingling is improved. He walks with a normal gait and normal heel-toe swing though gait, with no evidence of limp and there is no evidence of weakness walking on the toes or the heels. There is palpable tenderness over the left L4-5 and L5-S1 region; increased pain with extension and left greater than right lateral bending in range of motion and is improved with flexion. The MRI scan (3-4-13) of the lumbar spine report shows: Slight disc bulge at L4-5 and L5-S1; mild facet arthropathy L4-5 and L5-S1; mild left lateral recess stenosis L4-5. Work restrictions include no working more than eight hours a day, no lifting, pushing or pulling over 10 pounds. Medications include Ibuprofen 800 mg, Tramadol HCL 50 mg and Protonix Dr 20 mg. Current request for Left L4-5 and L5-S1 laminotomy and foraminotomy; right side L4-5 laminotomy; assisted surgeon; interoperative spinal cord monitoring.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left L4-5 and L5-S1 laminotomy and foraminotomy: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305, 306.

Decision rationale: Per AME dated 8/18/2014 the injured worker lifted a case of soda from 2 feet off the ground and felt sharp pain in the lower back on 1/10/2013. He underwent an MRI scan of the lumbar spine on 3/4/2013, which according to the AME showed a slight disc bulge at L4-5 and L5-S1, mild facet arthropathy at L4-5 and L5-S1, mild left lateral recess stenosis at L4-5, and otherwise normal remaining lumbar spine. A relatively recent progress note of 4/15/2015 indicates predominantly left-sided low back pain radiating down the left buttock and posterior thigh and occasionally into the calf. He also had intermittent right anterior thigh numbness. On examination, he walked with a normal gait. There was tenderness at the left L4-5 and L5-S1 region. Sensation to light touch and pinprick was intact in both lower extremities. There was increased pain with extension of the lumbar spine and left greater than right lateral bending. The knee jerks were 2+ bilaterally. The Achilles reflexes were also 2+ bilaterally. Motor strength was 5/5 in both lower extremities with the exception of extensor hallucis longus, which was 4/5 on the right. The provider suggested left L4-5 and L5-S1 laminotomy, foraminotomy, right L4-5 laminotomy, and foraminotomy. The MRI report has not been submitted. California MTUS guidelines indicate surgical considerations for severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies, preferably with accompanying objective signs of neural compromise, activity limitations due to radiating leg pain for more than one month or extreme progression of lower leg symptoms, clear clinical, imaging, and electrophysiologic evidence of a lesion that has been shown to benefit in both the short and long-term from surgical repair and failure of conservative treatment to resolve disabling radicular symptoms. The surgical discectomy for carefully selected patients with nerve root compression due to lumbar disc prolapse provides faster relief from the acute attack than conservative management, but any positive or negative effects on the lifetime natural history of the underlying disc disease are still unclear. In this case, severe and disabling lower leg symptoms have not been reported. The imaging study as reported does not show clear evidence of nerve root compression. Mild changes are reported. No sensory deficit was documented. The deep tendon reflexes were normal. There was no motor weakness with the exception of 4/5 extensor hallucis longus on the right. The guideline criteria have not been met. Therefore, the request is not medically necessary.

Right-sided L4-5 laminotomy: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints
Page(s): 305, 306.

Decision rationale: Per AME dated 8/18/2014 the injured worker lifted a case of soda from 2 feet off the ground and felt sharp pain in the lower back on 1/10/2013. He underwent an MRI scan of the lumbar spine on 3/4/2013, which according to the AME showed a slight disc bulge at L4-5 and L5-S1, mild facet arthropathy at L4-5 and L5-S1, mild left lateral recess stenosis at L4-5, and otherwise normal remaining lumbar spine. A relatively recent progress note of 4/15/2015 indicates predominantly left-sided low back pain radiating down the left buttock and posterior thigh and occasionally into the calf. He also had intermittent right anterior thigh numbness. On examination, he walked with a normal gait. There was tenderness at the left L4-5 and L5-S1 region. Sensation to light touch and pinprick was intact in both lower extremities. There was increased pain with extension of the lumbar spine and left greater than right lateral bending. The knee jerks were 2+ bilaterally. The Achilles reflexes were also 2+ bilaterally. Motor strength was 5/5 in both lower extremities with the exception of extensor hallucis longus, which was 4/5 on the right. The provider suggested left L4-5 and L5-S1 laminotomy, foraminotomy, right L4-5 laminotomy, and foraminotomy. The MRI report has not been submitted. California MTUS guidelines indicate surgical considerations for severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies, preferably with accompanying objective signs of neural compromise, activity limitations due to radiating leg pain for more than one month or extreme progression of lower leg symptoms, clear clinical, imaging, and electrophysiologic evidence of a lesion that has been shown to benefit in both the short and long-term from surgical repair and failure of conservative treatment to resolve disabling radicular symptoms. The surgical discectomy for carefully selected patients with nerve root compression due to lumbar disc prolapse provides faster relief from the acute attack than conservative management, but any positive or negative effects on the lifetime natural history of the underlying disc disease are still unclear. In this case, severe and disabling lower leg symptoms have not been reported. The imaging study as reported does not show clear evidence of nerve root compression. Mild changes are reported. No sensory deficit was documented. The deep tendon reflexes were normal. There was no motor weakness with the exception of 4/5 extensor hallucis longus on the right. The guideline criteria have not been met. Therefore, the request is not medically necessary.

Assistant surgeon: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Interoperative spinal cord monitoring: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.