

Case Number:	CM13-0010359		
Date Assigned:	12/04/2013	Date of Injury:	01/16/1996
Decision Date:	01/24/2014	UR Denial Date:	07/11/2013
Priority:	Standard	Application Received:	08/12/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Pain medicine 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 physician 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.

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 62-year-old male with a work-related injury to the lumbar spine. The original date of injury was January 16, 1996. Per an appeal report on date of service June 28, 2013, the injured worker is experiencing progression of symptoms regarding the lumbar spine. The patient reports "intractable lower back pain with radiation in the bilateral lower extremities." The symptoms are worse on the left compared to on the right. The patient describes paresthesias of the left lower extremity and on occasion will experience giving way sensation of the lower extremities. The patient's recent treatment has consisted of activity modification, home stretching program, low-impact exercise, and the use of narcotic analgesics. The patient has also tried a lumbar support. Physical examination performed on the date of service noted symmetrically diminished deep tendon reflexes of the lower extremities consistent with spinal stenosis. There is a mild degree of weakness of the right ankle and extensor hallucis longus. Sensory examination is grossly intact. MRI of the lumbar spine is further discussed indicates a marked degree of central canal stenosis at the L4 - 5 level secondary to hypertrophic changes of the facet joints and enter a list basis of L4 over L5 of 10 mm. The rationale for the spine surgery consultation is due to the progression of symptoms

IMR ISSUES, DECISIONS AND RATIONALES

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

The request for 1 Spinal Surgical Consultation with [REDACTED] for lumbar spine (lower back): Overturned

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,Chronic Pain Treatment Guidelines Page(s): 6.

Decision rationale: According to California Chronic Pain Medical Treatment Guidelines: "(a) The Administrative Director adopts and incorporates by reference the Low Back Complaints (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 12) into the MTUS from the ACOEM Practice Guidelines." According to ACOEM Low Back Chapter 12 page 305, section entitled "Surgical Considerations" specifies the following: "Within the first three months after onset of acute low back symptoms, surgery is considered only when serious spinal pathology or nerve root dysfunction not responsive to conservative therapy (and obviously due to a herniated disk) is detected. Disk herniation, characterized by protrusion of the central nucleus pulposus through a defect in the outer annulus fibrosis, may impinge on a nerve root, causing irritation, back and leg symptoms, and nerve root dysfunction. The presence of a herniated disk on an imaging study, however, does not necessarily imply nerve root dysfunction. Studies of asymptomatic adults commonly demonstrate intervertebral disk herniations that apparently do not cause symptoms. Some studies show spontaneous disk resorption without surgery, while others suggest that pain may be due to irritation of the dorsal root ganglion by inflammogens (metalloproteinases, nitric oxide, interleukin- 6, prostaglandin E2) released from a damaged disk in the absence of anatomical evidence of direct contact between neural elements and disk material. Therefore, referral for surgical consultation is indicated for patients who have: - Severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies (radiculopathy), 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 - Failure of conservative treatment to resolve disabling radicular symptoms" In the case of this injured worker, there has been extensive conservative management in the form of activity modification, low-impact exercise, home stretching program, lumbar support, in the use of narcotic analgesics. Despite these conservative measures, the patient continues with significant low back pain and radicular symptoms. Objective signs of nerve dysfunction are present. Physical examination performed on the date of service 6/28/13 noted symmetrically diminished deep tendon reflexes of the lower extremities consistent with spinal stenosis. There is a mild degree of weakness of the right ankle and extensor hallucis longus. Lumbar MRI indicates a significant degree of spondylolisthesis and marked spinal canal stenosis at the L4-5 level. Given the clinical picture and objective findings, the request for a spine surgery consultation is recommended for certification.