

Case Number:	CM14-0159646		
Date Assigned:	10/03/2014	Date of Injury:	09/14/2004
Decision Date:	10/29/2014	UR Denial Date:	09/25/2014
Priority:	Standard	Application Received:	09/29/2014

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 Orthopaedic Surgery 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 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:

This 51-year-old male sustained an industrial injury on 9/14/04. The mechanism of injury was not documented. Past surgical history was positive for L4/5 and L5/S1 anterior and posterior fusion with hardware removal and augmentation of fusion. According to the 3/4/14 pain management report, the patient had a 7 year history of constant moderately severe lower back pain radiating to the lower extremities and a recent increase in left leg pain. Physical exam documented no focal motor deficit, intact sensation, and normal reflexes. There was global left lower extremity 4/5 weakness noted. Straight leg raise test was positive on the right. Pain control was reported stable on current medications. The 8/28/14 lumbar spine CT scan impression documented compression fractures of the L1 and L2 vertebral bodies, further correlation with old studies was recommended. There were mild bilateral facet degenerative changes, a posterior disc bulge, and mild narrowing of the thecal sac at L2/3. There were moderate to severe bilateral facet degenerative changes, ligamentum flavum hypertrophy, posterior disc bulge, moderate to severe spinal stenosis, and mild to moderate bilateral lateral recess and neuroforaminal narrowing at L3/4. Postsurgical changes were noted at L4/5 with solid bony fusion, no evidence of spinal stenosis, and mild to moderate neuroforaminal narrowing due to a broad based posterior spur. Postsurgical changes were noted at L5/S1 with solid bony fusion, no central canal narrowing, and mild left neuroforaminal narrowing. The 9/15/14 treating physician report cited subjective complaints of bilateral leg pain and tight hamstrings. He ambulated with a cane. He was scheduled for bilateral lower extremity EMG/NCV study and was to follow-up with the pain management physician. Authorization was requested for orthopedic surgeon consult and treatment. A request for additional information was sent to the treating physician requested documentation of the medical necessity of this referral relative to change in symptoms that warranted consultation at this time or failure of conservative treatment. The 9/25/14 utilization

review denied the request for an orthopedic surgeon consult and treatment based on an absence of indications for the referral and documentation that the treating physician had exhausted treatments in his field or the patient did not respond as expected.

IMR ISSUES, DECISIONS AND RATIONALES

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

Orthopedic Surgeon Consult and Treatment: 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): 202.

Decision rationale: The California Medical Treatment Utilization Schedule guidelines state that referral for surgical consultation is indicated for patients who have met specific criteria. Referral 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. There should be activity limitations due to radiating leg pain for more than 4 to 6 weeks. Guidelines require clear clinical, imaging, and electrophysiologic evidence of a lesion that has shown to benefit in the short and long term from surgical repair. Failure of time and an adequate trial of conservative treatment to resolve disabling radicular symptoms must be documented. Guideline criteria have not been fully met. There is no current pain or functional assessment, or objective clinical signs of neural compromise documented in the provided records. Evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. Records indicate a lower extremity electrodiagnostic study is pending. This request for treatment with the orthopedic surgeon is non-specific and the medical necessity as such cannot be established. Therefore, this request is not medically necessary at this time.