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| Case Number: | CM15-0052505 | | |
| Date Assigned: | 07/16/2015 | Date of Injury: | 05/03/2007 |
| Decision Date: | 08/20/2015 | UR Denial Date: | 03/13/2015 |
| Priority: | Standard | Application Received: | 03/19/2015 |

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: California

Certification(s)/Specialty: Emergency Medicine

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 34 year old male who sustained an industrial injury on May 3, 2007. He has reported injury to the back radiating to the left lower extremity and has been diagnosed with lumbar radiculopathy left L5-S1 and lumbar disc degeneration at L5-S1. Treatment has included medical imaging, medications, home exercises, acupuncture, and injections. There was positive tenderness in the paravertebral muscles. Straight leg raise was positive on the left and negative on the right. Range of motion was restricted in all planes due to pain. Reflexes were diminished on the left 1 + Achilles, 2+ left patella. 5/5 strength on the right lower extremity with diminished strength on the left. Sensation was diminished on the left in the L5 and S1 distribution. Sensation in the right lower extremity was normal. The treatment request included Lumbar spine surgery evaluation x 1.

IMR ISSUES, DECISIONS AND RATIONALES

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

L/S Surgery evaluation: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Lumbar & Thoracic.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain, page 1, Part 1: Introduction Page(s): 1.

Decision rationale: The requested L/S Surgery evaluation, is medically necessary. California Medical Treatment Utilization Schedule (MTUS), 2009, Chronic pain, page 1, Part 1: Introduction, states "If the complaint persists, the physician needs to reconsider the diagnosis and decide whether a specialist evaluation is necessary." The injured worker has pain back radiating to the left lower extremity and has been diagnosed with lumbar radiculopathy left L5-S1 and lumbar disc degeneration at L5-S1. Treatment has included medical imaging, medications, home exercises, acupuncture, and injections. There was positive tenderness in the paravertebral muscles. Straight leg raise was positive on the left and negative on the right. Range of motion was restricted in all planes due to pain. Reflexes were diminished on the left 1 + Achilles, 2+ left patella. 5/5 strength on the right lower extremity with diminished strength on the left. Sensation was diminished on the left in the L5 and S1 distribution. The treating physician has documented sufficient symptoms, exam findings and conservative treatment trials to establish the medical necessity for a surgical evaluation. The criteria noted above having been met, L/S Surgery evaluation is medically necessary.