

Case Number:	CM14-0114590		
Date Assigned:	09/22/2014	Date of Injury:	05/22/2012
Decision Date:	10/21/2014	UR Denial Date:	07/09/2014
Priority:	Standard	Application Received:	07/22/2014

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 Orthopedic Surgery, has a subspecialty in Spine 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:

According to the records made available for review, this is a 45-year-old male with a 5/22/12 date of injury. At the time (7/1/14) of request for authorization for Orthopedic surgeon spine consultation for the low back, there is documentation of subjective complaints are low back pain, progressive numbness and tingling in the left leg, bilateral hip pain with numbness, and difficulty performing activities of daily living. The objective complaints include tenderness of the lumbar spine and positive straight leg raise on the left. Imaging findings include an MRI of the lumbar spine (2/20/13) which revealed no significant disc or nerve pathology. Current diagnoses include profound numbness and tingling in the left leg and right hip sprain/strain. Treatments to date are physical therapy, medications, and activity modification. Medical report identifies an EMG performed on 2/28/13 with normal findings and no evidence of lumbar or sacral radiculopathy. There is no documentation of disabling lower leg symptoms in the distribution consistent with abnormalities on imaging studies (radiculopathy), objective signs of neural compromise; and 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.

IMR ISSUES, DECISIONS AND RATIONALES

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

Orthopedic surgeon spine consultation for the low back: 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: MTUS reference to ACOEM Guidelines identifies documentation of severe and disabling lower leg symptoms in the 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; and failure of conservative treatment to resolve disabling radicular symptoms, as criteria necessary to support the medical necessity of a spine specialist referral. Within the medical information available for review, there is documentation of diagnoses of profound numbness and tingling in the left leg and right hip sprain/strain. In addition, given documentation of subjective findings (low back pain, progressive profound numbness and tingling in the left leg, bilateral hip pain with numbness, and difficulty performing activities of daily living), there is documentation of severe and disabling lower leg symptoms. There are activity limitations due to radiating leg pain and progression of lower leg symptoms; and failure of conservative treatment (physical therapy, medications, and activity modification) to resolve disabling radicular symptoms. However, given documentation of objective findings, imaging findings, and negative electrodiagnostic studies, there is no documentation of disabling lower leg symptoms in the distribution consistent with abnormalities on imaging studies (radiculopathy), objective signs of neural compromise; and 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. Therefore, based on guidelines and a review of the evidence, the request for orthopedic surgeon spine consultation for the low back is not medically necessary.