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| Case Number: | CM14-0162236 | | |
| Date Assigned: | 10/07/2014 | Date of Injury: | 08/05/2013 |
| Decision Date: | 11/07/2014 | UR Denial Date: | 09/19/2014 |
| Priority: | Standard | Application Received: | 10/02/2014 |

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 (Spine Fellowship Trained) 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 31-year-old male with an 8/5/13 date of injury. At the time (7/10/14) of request for authorization for 2nd Opinion with Orthopedic Spine Surgeon, there is documentation of subjective (radiating low back pain into the bilateral groin) and objective (antalgic gait, tenderness to palpitation over the left and right lumbar paravertebral regions at the L4-L5 and L5-S1 levels, and limited range of motion of the lumbar spine) findings, imaging findings (MRI of the lumbar spine (9/16/13) report revealed degenerative disc disease at L2-L3 and L5-S1 with annular tear at L5-S1, no spinal canal stenosis or nerve root impingement at any of the levels), current diagnoses (lumbosacral spondylosis, lumbar disc disorder, and lumbar spine radiculopathy), and treatment to date (acupuncture, physical therapy, Epidural Steroid injection, and medications). Medical reports identify that the pain is not well controlled with medications and it limits patient's daily activities and enjoyment of life. There is no documentation of persistent, 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; 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:

2nd Opinion with Orthopedic Spine Surgeon: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 288 and 303-306.

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

Decision rationale: MTUS reference to ACOEM Guidelines identifies the following criteria necessary to support the medical necessity of a spine specialist referral: documentation of persistent, 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; and failure of conservative treatment to resolve disabling radicular symptoms. Within the medical information available for review, there is documentation of diagnoses of lumbosacral spondylosis, lumbar disc disorder, and lumbar spine radiculopathy. In addition, there is documentation of failure of conservative treatment to resolve symptoms. However, there is no documentation of persistent, severe, and disabling lower leg symptoms, with accompanying objective signs of neural compromise, in a distribution consistent with radiculopathy. In addition, despite documentation that the pain is not well-controlled with medications and it limits patient's daily activities and enjoyment of life, there is no (clear) documentation of activity limitations due to radiating leg pain for more than one month. Furthermore, despite documentation of imaging findings (9/16/13 MRI of the lumbar spine revealed degenerative disc disease at L2-L3 and L5-S1 with annular tear at L5-S1, no spinal canal stenosis or nerve root impingement at any of the levels), there is no documentation of abnormalities on imaging studies consistent with lower leg symptoms and accompanying objective signs of neural compromise. Therefore, based on guidelines and a review of the evidence, the request for 2nd Opinion with Orthopedic Spine Surgeon is not medically necessary.