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| Case Number: | CM14-0182896 | | |
| Date Assigned: | 11/07/2014 | Date of Injury: | 09/25/1981 |
| Decision Date: | 12/11/2014 | UR Denial Date: | 10/03/2014 |
| Priority: | Standard | Application Received: | 11/03/2014 |

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 Surgeon and is licensed to practice in Georgia and South Carolina. 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:

The injured worker is a 60-year-old male who reported injuries of unspecified mechanism on 09/25/1981. On 10/07/2014, his diagnoses included cervicalgia with bilateral radiculopathy and severe cervicogenic headaches, rotoscoliosis of the total spine, status post fusion surgery x3, bilateral radiculopathy, bilateral knee replacement with pain, sleep disturbance, depression, anxiety, and bilateral shoulder arthropathy. On 10/01/2014, his complaints included constant lumbar spine pain radiating into both lower extremities, which was variable in intensity. It was aggravated by any motion or change in body position. It was alleviated by activity modification and sleeping in a recliner. He ambulated with a cane. It was noted that his symptoms were increasing progressively. His medications included MS-Contin ER 200 mg, Duragesic patch 100 mcg, Butrans patch 20 mcg, oxycodone 30 mg, Cymbalta 60 mg, Lunesta 3 mg, Valium 10 mg, Soma 350 mg, Prilosec 20 mg, trazodone 50 mg, Terocin 4% lidocaine patch, and Sprix nasal Toradol spray. He received an epidural steroid injection on 08/22/2014, which did help him with some pain relief and slightly better range of motion. The rationale for the requested surgery was purely for structural reasons and not trying to relieve his pain, which was deemed appropriate because his nerves had been stretched in such a way that he was suffering from neuropathic pain, which would have to be controlled by other means. There was no Request for Authorization included in this worker's chart.

IMR ISSUES, DECISIONS AND RATIONALES

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

Outpatient Lumbar Surgery with [REDACTED]: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307. Decision based on Non-MTUS Citation ODG-TWC Low Back Procedure Summary last updated 8/22/14, Lumbar Spinal Fusion

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

Decision rationale: The California ACOEM Guidelines note that within the first 3 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. 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 1 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. The request as submitted did not specify a type of surgery, the spinal level at which the surgery was to have taken place, or whether the surgery was to have been unilateral or bilateral. The guidelines do not support this request as submitted. Therefore, this request for outpatient lumbar surgery with [REDACTED] is not medically necessary.