

<b>Case Number:</b>	CM13-0065115		
<b>Date Assigned:</b>	01/03/2014	<b>Date of Injury:</b>	02/08/2012
<b>Decision Date:</b>	05/22/2014	<b>UR Denial Date:</b>	12/02/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/12/2013

### 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 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:

The patient is a 44 year old female who was injured on 02/08/2012. She was knocked down by a dog and lost her balance. She landed onto her buttocks in a sitting position then onto her back, onto the steps of the stairway. She felt immediate pain in her back. Prior treatment history has included physical therapy, chiropractic adjustments which did not provide any benefit; trigger point injections and lumbar epidural injection which increased her low back pain; Tramadol, nabumetone and cyclobenzaprine for pain. Diagnostic studies reviewed include MRI of the lumbar spine dated 07/23/2012 revealed lumbar muscular spasm; mild spondylosis L3-4, L4-5 and L4-S1; 3 mm left intraforaminal L4-5 disc protrusion causing mild left L4-5 neural foraminal stenosis; and 3 mm bilateral intraforaminal L5-S1 causing mild bilateral L5-S1 neural foraminal stenosis. AME report dated 12/05/2013 indicated the patient presented with complaints of aching and sharp pain radiating into her hips, buttocks and legs reaching to her feet. She had numbness and tingling in both legs. She was experiencing weakness in her left leg, which had even given out on several occasions. On examination, the patient's stood in a balanced and symmetrical manner. She had a slow caution moderate gait pattern bilaterally. The lower extremities reflexes were 2+ bilaterally. There was normal sensation to testing bilaterally; normal strength bilaterally. There was moderate tenderness over the lumbar midline with moderate spasm bilaterally; supine straight leg raise was 30 degrees with moderate to severe pain in the low back bilaterally. The patient was diagnosed with possible herniated nucleus pulposus, L3-L4 with amplification features. The possibility of surgery for this patient is under consideration for the lesion at L3-L4. It was stated that the most important aspect of his case is the fact that the patient's physical examination did not point distinctly to any specific nerve root lesion. Most disconcertingly, is the fact that the applicant's straight leg raise test was markedly positive at 30 degrees bilaterally. It was recommended the patient go back to rethink the entire situation. A

repeat MRI to see if there is a CSF leak is in order. If the leak is detected, then a blood patch or some other therapeutic measure will be necessary, considering how long the applicant has had spinal headaches since the procedure.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**ONE RE-EVALUATION BY SPINE SURGEON:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305.

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

**Decision rationale:** The CA MTUS ACOEM guidelines state physical examination evidence of severe neurologic compromise that correlates with the medical history and test results may indicate a need for surgical consultation. Based on the lumbar MRI findings, the patient does not have a true surgical lesion. Furthermore, physical examination by the AME on 12/05/2013 demonstrated normal motor, sensory and reflexes throughout the bilateral lower extremities. The AME noted there were inconsistencies with subjective report and findings with supine versus seated SLR. According to the medical report dated 11/13/2013, examination showed decreased sensation with pain in the L4, L5 and S1 left dermatomal distributions. The report of pain with sensory testing would indicate sensation is not decreased in those dermatomes. The medical records do not demonstrate there is clear and consistent evidence of any specific nerve root lesion. The medical records do not establish this patient is a clear surgical candidate. The AME opined that the LESI was not effective because it was administered at the wrong level. He recommended a repeat MRI to evaluate for potential CSF leakage. The medical records do not demonstrate conservative measures have been exhausted. The medical necessity for re-evaluation by spine surgeon has not been established.