

<b>Case Number:</b>	CM14-0020258		
<b>Date Assigned:</b>	04/25/2014	<b>Date of Injury:</b>	08/24/2012
<b>Decision Date:</b>	07/07/2014	<b>UR Denial Date:</b>	02/10/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/18/2014

### 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 and is licensed to practice in Texas. 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 44 year old male who reported an injury to his low back. The clinical note dated 01/28/13 indicates the injured worker stated the initial injury occurred to his low back on 08/24/12 as a result of lifting the end of a pallet jack. The note indicates the injured worker having undergone an epidural steroid injection in the low back. The injured worker stated the low back pain was affecting his ability to complete his activities of daily living. There is an indication the injured worker has undergone a full course of conservative therapy as well as a home exercise program and the continued use of antiinflammatory medications as well as muscle relaxants. The injured worker described the low back pain as moderate to severe with radiation of pain into the left leg. Pain was also identified as radiating to both buttocks and the groin. Prolonged sitting, standing, and walking all exacerbated the injured worker's pain. The pain was described as a shooting and stabbing sensation with a burning quality. The injured worker rated the pain as 6-9/10 at that time. Limited range of motion was identified throughout the lumbar spine. Reflex deficits were identified at the left knee. Weakness was also identified in the left lower extremity in the L3 and L4 myotomes. The clinical note dated 09/02/13 indicates the injured worker rating his low back pain as 8-9/10. The injured worker also reported numbness and tingling in both lower extremities. Upon exam, the injured worker was able to demonstrate 7 degrees of lumbar extension, 15 degrees of left lateral flexion, 10 degrees of right lateral flexion, 15 degrees of left rotation, and 10 degrees of right rotation. 4/5 strength was identified throughout both lower extremities. Decreased sensation was identified in the L4, L5, and S1 dermatomes bilaterally. The clinical note dated 10/21/13 indicates the injured worker continuing with numbness and tingling in both lower extremities. The injured worker continued to rate the pain in the low back as 8-9/10. The clinical note dated 11/15/13 indicates the injured worker ambulating with a slightly antalgic gait. The injured worker was identified as guarding when

sitting and changing positions. The injured worker was able to heel walk; however, pain was identified at the right posterior thigh. The injured worker was able to demonstrate 30 degrees of lumbar flexion with continued range of motion deficits identified with extension and side bending. Hypertonicity and tenderness were identified throughout the lumbar spine, paravertebral musculature, as well as the sacroiliac joint. The MRI of the lumbar spine dated 01/20/14 revealed a small disc bulge at L3-4 with a central annular fissure and an early disc protrusion contributing to minimal central canal stenosis. The clinical note dated 02/10/14 indicates the injured worker being recommended for a bilateral laminotomy at L3-4. The clinical note dated 02/12/14 indicates the injured worker having previously undergone a utilization review which resulted in a denial for certification of a requested surgery to include a laminectomy at L3-4. The reason for the denial was as a result of inconclusive findings regarding confirmation of the injured worker's pathology by imaging studies and diffuse neurologic findings identified on clinical exam.

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

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

#### **BILATERAL L3-4 LAMINOTOMIES: 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): 306-307.

**Decision rationale:** The documentation indicates the injured worker complaining of ongoing low back pain with radiation of pain to the lower extremities. A laminotomy would be indicated in the lumbar region provided the injured worker meets specific criteria to include imaging studies confirming the injured worker's significant pathology and a clinical exam corroborates the injured worker's clinical findings supporting the proposed surgical procedure. The submitted MRI revealed minimal findings at the L3-4 level. Additionally, the injured worker's neurologic deficits appear to be diffused in nature. There is an indication that the injured worker has 4/5 strength throughout both lower extremities involving all muscle groups. Additionally, there is an indication the injured worker has sensation deficits involving the L4, L5, and S1 distributions. Given these findings, the requested laminotomy at L3-4 is not fully supported at this time.

#### **ASSISTANT SURGEON: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**INTERNAL MEDICINE CLEARANCE: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**POSTOPERATIVE PHYSICAL THERAPY (24 VISITS): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**OFF THE SHELF LUMBAR BRACE: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**FRONT WHEELED WALKER: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**ONE NIGHT HOSPITALIZATION: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**HOME HEALTH EVALUATION:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.