

<b>Case Number:</b>	CM14-0026841		
<b>Date Assigned:</b>	06/13/2014	<b>Date of Injury:</b>	09/28/2010
<b>Decision Date:</b>	07/16/2014	<b>UR Denial Date:</b>	02/13/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/03/2014

### 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 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 60-year-old male who reported an injury to his low back on 09/28/2010. The computerized tomography (CT) scan of the lumbar spine dated 07/26/13 revealed a slight narrowing of the thecal sac at L4-5 with moderate right-sided neuroforaminal stenosis and mild left neuroforaminal stenosis. Moderate to severe right-sided neuroforaminal stenosis was identified at L5-S1. The clinical note dated 10/28/13 indicates the injured worker able to demonstrate 35 degrees of lumbar flexion and 15 degrees of extension. The procedural note dated 01/16/14 indicates the injured worker undergoing an epidural steroid injection at the L5-S1 level. The clinical note dated 02/17/14 indicates the injured worker having complaints of difficulty with sleep secondary to the low back complaints. There is an indication the injured worker has undergone an MRI, which did reveal a disc herniation at L5-S1. The injured worker had undergone two (2) sets of epidural injections did provide the injured worker with up to eight (8) months of relief. The clinical note dated 02/24/14 indicates the injured worker complaining of tenderness at the lumbosacral junction. The injured worker had a positive straight leg raise on the left. The injured worker demonstrated mild weakness in the quadriceps on the left compared to the right. The utilization review dated 02/13/14 resulted in a denial as no information had been submitted regarding the injured worker's completion of all conservative treatments. No information had been submitted confirming the injured worker's completion of formal conservative therapy. Additionally, no information had been submitted regarding the injured worker's significant neurologic deficits confirmed by clinical exam.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**BILATERAL FORAMINOTOMIES AND LAMINOTOMIES WITH DECOMPRESSION OF NEURAL ELEMENTS AT THE LEVEL OF L4-S1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 306. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back - Lumbar & Thoracic (Acute & Chronic).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307.

**Decision rationale:** The documentation indicates the injured worker complaining of ongoing low back pain. A foraminotomy and laminotomy with a decompression is indicated in the lumbar region provided the injured worker meets specific criteria to include completion of all conservative treatments and the injured worker has demonstrated significant radiculopathy in the appropriate distributions. There is an indication the injured worker has undergone 3 epidural steroid injections. However, no information was submitted regarding the injured worker's recent completion of any formal therapeutic interventions. Additionally, the injured worker was able to demonstrate 5/5 strength with no significant reflex or sensation deficits in the L4, L5, or S1 distributions. Given these findings, this request is not indicated as medically necessary.

**ONE (1) DAY INPATIENT STAY: 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 (1) CO-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.

**PREOPERATIVE MEDICAL CLEARANCE TO INCLUDE CONSULTATION: 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.

**FOURTEEN (14) DAYS OF ICELESS COLD THERAPY UNIT WITH DVT AND LUMBAR WRAP:** 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.

**PREOPERATIVE MEDICAL CLEARANCE TO INCLUDE LABS (COMPLETE BLOOD COUNT, COMPREHENSIVE METABOLIC PANEL, PROTHROMBIN TIME, PARTIAL THROMBOPLASTIN TIME, URINALYSIS):** 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.

**PREOPERATIVE MEDICAL CLEARANCE TO INCLUDE A CHEST X-RAY:** 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.

**PREOPERATIVE MEDICAL CLEARANCE TO INCLUDE AN ELECTROCARDIOGRAM (EKG):** 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.