

<b>Case Number:</b>	CM14-0033907		
<b>Date Assigned:</b>	06/20/2014	<b>Date of Injury:</b>	05/03/2007
<b>Decision Date:</b>	07/28/2014	<b>UR Denial Date:</b>	02/20/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/18/2014

### 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 Spine 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 40-year-old male who reported an injury on 05/03/2007. The mechanism of injury involved a fall. Current diagnoses include lumbar herniated disc, left shoulder subacromial impingement, cerebral concussion with cervical spine sprain, right wrist sprain, right wrist traumatic radial styloid tenosynovitis, contusion to the head, left shoulder injury, lumbar sprain, and contusion to the lower back. The only documentation submitted for this review is an Agreed Medical Examination on 04/23/2014. The injured worker reported persistent left shoulder, low back and right leg pain. Previous conservative treatment includes physical therapy, activity limitation and medication management. Physical examination of the lumbar spine revealed a limping gait, loss of lumbar lordosis, tenderness to palpation, paravertebral muscle spasm, and diminished range of motion. The injured worker also demonstrated positive straight leg raising, decreased sensation, and 4/5 motor strength on the right. Future medical treatment included maintenance contact for periodic access of prescriptions and modalities of care, and injections. Operative treatment was not indicated.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **1 Unspecified Low Back Surgery with inpatient stay: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

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

**Decision rationale:** The ACOEM Guidelines indicate a referral for surgical consultation may be indicated for patients who have severe and disabling lower extremity symptoms, activity limitation for more than 1 month, clear clinical, imaging and electrophysiologic evidence of a lesion, and a failure of conservative treatment. The specific type of low back surgery requested was not listed. Therefore, the current request is not medically necessary and appropriate.