

<b>Case Number:</b>	CM15-0191535		
<b>Date Assigned:</b>	10/29/2015	<b>Date of Injury:</b>	06/25/2014
<b>Decision Date:</b>	12/10/2015	<b>UR Denial Date:</b>	08/20/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/29/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: New York, Montana, California  
 Certification(s)/Specialty: Neurological Surgery

### 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 48 year old male, who sustained an industrial injury on June 25, 2014. The injured worker was diagnosed as having lumbago, lumbar disc protrusion, lumbar musculoligamentous injury, lumbosacral sprain and strain, left shoulder impingement syndrome, left shoulder injury, left shoulder internal derangement, left shoulder pain, left shoulder sprain and strain and left shoulder tenosynovitis. Treatment to date has included diagnostic studies, injection, shockwave treatment, chiropractic treatment, acupuncture and medication. An epidural injection was noted to give him relief for five days but then the pain returned. On June 9, 2015, the injured worker complained of left shoulder pain, especially with overhead manipulation. An MRI was noted to document rotator cuff tendinitis. The treatment plan included left shoulder arthroscopy. On August 25, 2015, the injured worker complained of low back pain radiating to the bilateral thighs. Physical examination of the lumbar spine revealed tenderness to palpation over the paraspinal musculature. Range of motion included flexion 60 degrees, extension 25 degrees, right bend 25 degrees and left bend 25 degrees. An MRI was noted to show severe foraminal stenosis. The treatment plan included L5 to S1 decompression and fusion. On August 30, 2015, utilization review denied a request for pre-op clearance history and physical, chest x-ray, post-op physical therapy two times eight for the low back, pre-op urinalysis, pre-op EKG and inpatient stay times three days.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Pre-op clearance; History and physical:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Surgical Considerations.

**Decision rationale:** The California MTUS guidelines do recommend lumbar surgery if there is clear clinical, electrophysiological and imaging evidence of specific nerve root or spinal cord level of impingement which would correlate with severe, persistent debilitating lower extremity pain unresponsive to conservative management. Documentation does not provide this evidence. The provider opines that the foraminal stenosis accounts for the sensory findings, but neglects to provide electrophysiological evidence of a L5 radiculopathy or explain how the sensory deficit would not be accompanied with any motor findings. The California MTUS guidelines do recommend spinal fusion for fracture, dislocation and instability. Documentation does not provide evidence of these conditions. Since the lumbar decompression and fusion is not medically necessary and appropriate, then the requested treatment: Pre-op clearance; History and physical is not medically necessary and appropriate.

**Chest x-ray:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Preoperative testing.

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

**Decision rationale:** Since the lumbar decompression and fusion is not medically necessary and appropriate, the requested treatment: Pre-op chest x-ray is not medically necessary and appropriate.

**Post-op physical therapy 2 x 8 for the low back:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment 2009, Section(s): Low Back.

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

**Decision rationale:** Since the lumbar decompression and fusion is not medically necessary and appropriate, the requested treatment: Post-op physical therapy 2 x 8 for the low back is not medically necessary and appropriate.

**Pre-op Urinalysis:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Preoperative lab testing.

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

**Decision rationale:** Since the lumbar decompression and fusion is not medically necessary and appropriate, the requested treatment: Pre-op Urinalysis is not medically necessary and appropriate.

**Pre-op EKG:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Preoperative electrocardiogram.

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

**Decision rationale:** Since the lumbar decompression and fusion is not medically necessary and appropriate, the requested treatment: Pre-op EKG is not medically necessary and appropriate.

**Associated surgical service: Inpatient stay x 3 days:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Hospital length of stay.

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

**Decision rationale:** Since the lumbar decompression and fusion is not medically necessary and appropriate, the requested treatment: Associated surgical service: Inpatient stay x 3 days is not medically necessary and appropriate.