

<b>Case Number:</b>	CM14-0138112		
<b>Date Assigned:</b>	09/05/2014	<b>Date of Injury:</b>	07/10/2013
<b>Decision Date:</b>	10/02/2014	<b>UR Denial Date:</b>	08/15/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/25/2014

### 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 Occupational Medicine 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 claimant was injured due to cumulative trauma from 12/01/12 through 08/02/13. 12 post-op therapy sessions for the lumbar spine are under review. She was diagnosed with acquired spondylolisthesis and has chronic low back pain with left thigh pain. She has had conservative therapy including PT, medication, and activity modification. The therapy improved her symptoms but she still has pain. On 04/14/14, she had decreased range of motion with intact motor at 5/5 and negative straight leg raise. There were no abnormal reflexes and no focal deficits. She had an AME with [REDACTED] on 04/23/14. An updated magnetic resonance imaging (MRI) was ordered at that time. A magnetic resonance imaging (MRI) dated 07/24/14 revealed spondylolisthesis at L4-5 with no disc bulges, protrusion or central or foraminal stenosis. There was a diffuse disc bulge at L5-S1 with no root compression. Anterior and posterior fusion was recommended at L4-5 and L5-S1 along with 12 post-op physical therapy sessions. Surgery was not certified and therefore postop therapy was not certified.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**12 Post Op Therapy Sessions for the lumbar spine 2 times per week for 6 weeks:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): Pages 305-308.

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 23.

**Decision rationale:** The history and documentation do not objectively support the request for 12 visits of post-op physical therapy for the lumbar spine. The MTUS recommend "Intervertebral disc disorders without myelopathy Post-surgical treatment (fusion): 34 visits over 16 weeks (beginning with one half the total recommended as initial care followed by a reassessment. Postsurgical physical medicine treatment period: 6 months." The initial review indicates that surgery was recommended but was not approved and there is no other information that states it has been approved. As a result, the medical necessity of postoperative PT for the lumbar spine has not been clearly demonstrated. The request for 12 Post-Op Therapy Sessions for the lumbar spine 2 times per week for 6 weeks is not medically necessary.