

Case Number:	CM14-0057463		
Date Assigned:	07/09/2014	Date of Injury:	06/01/2007
Decision Date:	08/25/2014	UR Denial Date:	04/16/2014
Priority:	Standard	Application Received:	04/28/2014

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 Physical Medicine and Rehabilitation 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 injured worker is a 49-year-old male who was reportedly injured on 6/1/2007. The mechanism of injury was noted as cumulative trauma. The injured worker underwent a lumbar spine fusion at L2-L3 and L5-S1 on 1/11/2012. The most recent progress notes dated 2/20/2014 and 2/21/2014, indicate that there were ongoing complaints of low back pain with radiation to the lower extremities. Physical examination demonstrated a midline surgical scar and pain with palpation, lumbar range motion were flexion 61, extension 14 and lateral bending 22/25. Straight leg raise test resulted in back pain. Plain radiographs of the lumbar spine, dated 2/27/2012, demonstrated 3 mm of retrolisthesis at L3-L4 in flexion that reduced in extension, and 6 mm of retrolisthesis at L4-L5 in flexion that reduced to 1 mm in extension. Computed tomography scan of the lumbar spine, dated 4/24/2012, revealed disk bulges with central canal narrowing at L2-L3 through L5-S1. An electromyography/nerve conduction velocity study of the lower extremities, dated 7/18/2013, was normal. Previous treatment included the following medications: Norco 10/325 and diclofenac XR 100 mg. A request was made for #12 postoperative physical therapy visits and removal of hardware from L2-L3 and L5-S1 and exploration for possible pseudoarthrosis and decompression and instrumentation and fusion L3-L5, which was not certified in the utilization review on 4/16/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

12 Post-operative Physical Therapy Visits: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 13-27. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back Chapter, Online Version: Hardware Implant Removal (Fixation).

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

Decision rationale: The injured worker does not meet criteria to proceed with lumbar spine fusion at this time. Therefore, postoperative physical therapy is not medically necessary.

1 Removal of Metal at the L2-L3 and L5-S1 Levels, Exploration for Possible Pseudoarthrosis and Repair, Decompression, Laminectomy, Discectomy of L3-L4 and L5 with Posterolateral Fusion, Bone Graft, Pedicle Screw Fixation and Posterior Antibody Fusion with Implants: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 13-27. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back Chapter, Online Version: Hardware Implant Removal (fixation).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

Decision rationale: American College of Occupational and Environmental Medicine practice guidelines support a lumbar spinal fusion for fracture, dislocation, spondylolisthesis, instability or evidence of tumor/infection. Additional criteria required for a spinal fusion include back pain greater than 6 months with failure to conservative treatment. Review of the available medical records documented instability at L3-L4 and L4-L5 but failed to list any conservative treatment to include physical therapy and/or epidural steroid injections. Furthermore, the current magnetic resonance image and flexion/extension plain radiographs were older than a year and would need to be repeated prior to surgical intervention. Given the lack of documentation, this request is not considered medically necessary.