

<b>Case Number:</b>	CM14-0146511		
<b>Date Assigned:</b>	09/12/2014	<b>Date of Injury:</b>	11/05/2009
<b>Decision Date:</b>	10/16/2014	<b>UR Denial Date:</b>	08/19/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/09/2014

### 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 Neurological Surgery 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 records, presented for review, indicate that this 42-year-old male was reportedly injured on November 5, 2009. The mechanism of injury was noted as lifting a heavy box. The most recent progress note, dated August 25, 2014, indicated that there were ongoing complaints of low back pain with radiation into bilateral lower extremities. Physical examination demonstrated an alert and oriented individual in no acute distress. It was noted that the patient was uncomfortable during the exam. Gait was severely antalgic and slow, requiring the use of a single point cane. There was tenderness to palpation of the lumbar paraspinal muscles, with spasm. Range of motion of the lumbar spine was decreased in all planes. There was decreased sensation to the bilateral L4, L5, and S1 dermatomes. Motor exam was limited by pain, and strength was slightly decreased to 4/5 to bilateral lower extremities. Straight leg raise test was positive bilaterally. Slump test was positive bilaterally. Diagnostic imaging studies were not included for review, but the most recent progress note commented on an MRI of the lumbar spine from May 2013, which showed L5-S1 anterolisthesis with bilateral spondylolysis but without evidence for canal stenosis or neural foraminal narrowing at any level. Previous treatment included acupuncture, massage, epidural steroid injections, multiple medications, and physical therapy. A request has been made for direct pars repair of bilateral L5, followup visit, pain psychology consultation, postoperative chiropractic/physiotherapy (two visits a week for six weeks), and preoperative medical clearance including an EKG, chest x-ray, and preoperative lab work, and were not certified in the pre-authorization process on August 19, 2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Direct pars repair bilateral L5: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Case Reports in Medicine volume 2013, Article ID 659078, 5 pages and University of Miami Miller School of Medicine, Lois Pope Life Center.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Wheelless' Textbook of Orthopaedics; Spondylolysis and Type I Spondylolisthesis; Treatment: Symptomatic Spondylolysis; (electronically cited).

**Decision rationale:** The California MTUS and ODG do not address this request. A literature search revealed that symptoms from spondylolysis will commonly resolve with nonoperative care and activity limitation. Patients with painful spondylolysis, with minimal or no slip, should be treated conservatively for at least 6 to 8 months. If symptoms persist, in spite of activity modification, bracing or surgery might be indicated. Bracing should be for 6 to 8 months, followed by gradual brace removal. Painful spondylolysis not responding to orthosis after 6 to 8 months may require surgery. If there is L5 pars defect, an L5-S1 arthrodesis should be done. Chronically painful L4 pars defect without displacement is probably best treated by a direct repair of the lesion, which preserves good lumbar spine motion. The claimant has imaging evidence of Grade I anterolisthesis at L5-S1 with bilateral L5 spondylolysis, without evidence of instability. While the clinician's documentation indicates that the patient continues to suffer from ongoing symptoms and neurological deficits, there is no indication that orthosis has been attempted. Therefore, the request for direct pars repair of bilateral L5 is not medically necessary.

**Post-operative Chiropractic/Physiotherapy 2 x 6 visits: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

**Decision rationale:** While the MTUS does support postoperative therapy and the use of chiropractic therapy for low back pain as an option, the request for surgical intervention, specifically direct pars repair of bilateral L5, is not considered medically necessary, and therefore, postoperative chiropractic therapy and physiotherapy is not medically necessary.

**Follow-up Visit: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

**Decision rationale:** Although the ACOEM guidelines recommend postsurgical followup, the request for surgical intervention, specifically direct pars repair of bilateral L5, is not considered medically necessary, and therefore, postoperative followup visits are not medically necessary.

**Pain Psychology Consultation:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004): Low Back Complaints, Introductory Material, Surgical Considerations, (electronically cited).

**Decision rationale:** Although the ACOEM guidelines recommend that clinicians consider a referral for psychological screening prior to surgery to improve surgical outcomes, the request for surgical intervention, specifically direct pars repair of bilateral L5, is not considered medically necessary, and therefore, a pain psychology consultation is not medically necessary.

**Pre-operative Medical Clearance: EKG; Chest X-ray and Labs:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Preoperative Evaluation; American Family Physician. 2000 July 15; 62(2): 396.

**Decision rationale:** While this topic is not addressed by the MTUS, ACOEM, or ODT, a literature search confirms that routine preoperative medical clearance is recommended to determine whether the patient is a good surgical candidate and to avoid complications during a surgical procedure. However, the request for surgical intervention, specifically direct pars repair of bilateral L5, is not considered medically necessary, and therefore, preoperative medical clearance, including an EKG, chest x-ray, and lab work, is not medically necessary.