

Case Number:	CM14-0149680		
Date Assigned:	09/23/2014	Date of Injury:	12/05/2011
Decision Date:	11/12/2014	UR Denial Date:	09/10/2014
Priority:	Standard	Application Received:	09/15/2014

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 Surgeon, 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 54-year-old male who reported injury on 12/05/2011. The prior treatments included epidural steroid injection, and medications. Other therapies were not provided. The mechanism of injury was not provided. The injured worker underwent an MRI of the lumbar spine on 02/26/2014 which revealed at the level of L4-5 there was a broad base disc bulge too small to quantify, accompanied by mild to moderate bilateral facet ligament flavum hypertrophy resulting in flattening of the thecal sac and mild right sided neural foraminal narrowing. The left neural foramen was patent. At L5-S1 there was a broad based disc bulge too small to quantify accompanied by a central annular tear and mild to moderate bilateral facet ligamentum flavum hypertrophy resulting in minimal bilateral neural foraminal narrowing and no significant central canal stenosis. Documentation of 07/11/2014 revealed the injured worker had left lower extremity numbness, tingling, and pain. The documentation indicated the pain affected the injured worker's activities of daily living and functional capacity. The straight leg raise was positive on the left. The EHL, tibialis anterior and gastrosoleus strength was 4/5 on the left with decreased light touch in the posterior aspect of the calf. There was sciatic notch tenderness on the left. There were paraspinal spasms and tenderness of the lumbar spine. The physician documented he reviewed the MRI of the lumbar spine and it was consistent with a 2 mm to 3 mm disc herniation at L4-5 and L5-S1 causing lateral recess stenosis on the left side and compressing the traversing L5 nerve root and S1 nerve root. The diagnoses were herniated nucleus pulposus L4-5 and L5-S1 with lower extremity radiculopathy. The treatment plan included lumbar laminotomies, medial facetectomy, and possible microdiscectomy on the left side at L4-5 and L5-S1. The documentation indicated the injured worker failed maximum non-operative treatment including epidural steroid injections. The subsequent documentation dated 08/08/2014 revealed the same recommendation. Furthermore, the documentation indicated the

injured worker would like to have his care transferred to another physician. The injured worker underwent a subsequent MRI of the lumbar spine on 06/23/2014 which revealed at L5-S1 there was a 2 mm to 3 mm central protrusion with mild neural foraminal narrowing bilaterally without significant central spinal canal stenosis. At the level of L4-5 there was a 2 mm to 3 mm broad based disc bulge causing mild neural foraminal narrowing bilaterally. There was a subtle high intensity zone seen in the posterior annulus consistent with a posterior annular tear. There was no significant central spinal canal stenosis. The injured worker underwent electrodiagnostic studies on 04/01/2014 which revealed evidence of a mild acute L5 radiculopathy on the left. There was a detailed Request for Authorization submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

18 sessions of post op physical therapy 3 times weekly for 6 weeks; for the lumbar spine:
Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 10, 26.

Decision rationale: The postsurgical treatment guidelines indicate that 16 visits of therapy are appropriate postoperatively for a discectomy and that the initial number of sessions is half the number of the recommended number, which would support 8 visits. There was a lack of documentation indicating that the surgical intervention was found to be medically necessary. 18 sessions would be excessive. Given the above, the request for 18 sessions of post op physical therapy 3 times weekly for 6 weeks; for the lumbar spine is not medically necessary.