

<b>Case Number:</b>	CM15-0071246		
<b>Date Assigned:</b>	04/21/2015	<b>Date of Injury:</b>	08/23/2010
<b>Decision Date:</b>	05/22/2015	<b>UR Denial Date:</b>	03/16/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/14/2015

### 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: Illinois, California, Texas  
 Certification(s)/Specialty: Orthopedic 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 55-year-old male who sustained an industrial injury on 8/23/10. The mechanism of injury was not documented. The injured worker underwent L1/2 transforaminal discectomy and fusion at 10/6/14. The 2/25/15 treating physician indicated that the patient was status post L1/2 fusion with improvement in his left leg pain. Within several weeks after the surgery, he developed increasing low back pain lower than the fusion site with right leg radiation. The new MRI showed disc herniation at L2/3 with an extruded component producing lateral recess and central canal stenosis with prior surgery noted at L3/4. He had right leg radiation consistent with L3 dermatomal distribution mainly on the anterior surface of his thigh with some knee extension weakness consistent with the L3/4 nerve root. Additional authorization would be requested for the right L3/4 microdiscectomy, but initial authorization was requested for L2/3 right microdiscectomy. The 3/16/15 utilization review certified the request for right sided L2/3 microdiscectomy, pre-operative clearance, and 2-day inpatient stay. The request for post-op aquatic therapy 3x6 for the low back was non-certified as there was no documentation intolerance to a land-based physical therapy program or evidence that he could not participate in a prescribed and self-administered program. The request for lumbar MRI was non-certified as there was no evidence that symptoms had changed since the most recent MRI. The request for a soft back brace was non-certified as there was no guideline support unless there was fusion surgery.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Post-operative aquatic therapy 3x6 for low back:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic therapy Page(s): 22, Postsurgical Treatment Guidelines Page(s): 26.

**Decision rationale:** The California MTUS guidelines support the use of aquatic therapy as an optional form of exercise therapy, as an alternative to land-based physical therapy. Aquatic therapy is specifically recommended where reduced weight bearing is desirable, for example extreme obesity. The California Post-Surgical Treatment Guidelines for discectomy/laminectomy suggest a general course of 16 post-operative visits over 8 weeks during the 6-month post-surgical treatment period. Guideline criteria have not been met. Post-operative physical therapy would be reasonable for this injured worker. However, there is no rationale in the provided records to support the medical necessity of aquatic therapy over standard land-based physical therapy for post-operative rehabilitation. There is no evidence of comorbidities, such as extreme obesity, that would make reduced weight bearing desirable. Therefore, this request is not medically necessary.

**Associated surgical service: MRI without contrast of lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Lumbar & Thoracic: MRIs (magnetic resonance imaging).

**Decision rationale:** The California MTUS guidelines state that unequivocal objective findings of specific nerve compromise on the neurologic exam are sufficient to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. The Official Disability Guidelines state the repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (e.g., tumor, infection, fracture, neurocompression, or recurrent disc herniation). Guideline criteria have not been met. Records indicated that a recent lumbar spine MRI had been performed. There is no evidence in the submitted records that there was a significant change in findings to warrant a repeat MRI. Therefore, this request is not medically necessary.

**Associated surgical service: soft back brace:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back, Back brace, Post-operative.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM). Occupational Medical Practice Guidelines 2nd Edition. Chapter 12 Low Back Disorders. (Revised 2007) page(s) 138-139.

**Decision rationale:** The California MTUS guidelines state that lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. The revised ACOEM Low Back Disorder guidelines do not recommend the use of lumbar supports for prevention or treatment of lower back pain. However, guidelines state that lumbar supports may be useful for specific treatment of spondylolisthesis, documented instability, or post-operative treatment. The use of a back brace following surgery is reasonable for pain control. Therefore, this request is medically necessary.