

<b>Case Number:</b>	CM14-0143769		
<b>Date Assigned:</b>	09/12/2014	<b>Date of Injury:</b>	08/30/1976
<b>Decision Date:</b>	11/24/2014	<b>UR Denial Date:</b>	08/08/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/05/2014

### 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:

This is a 61 year old male with a 8/30/76 injury date. The mechanism of injury was a motorcycle accident over 30 years ago. In a follow-up on 4/25/14, he complains of low back and leg pain for the past 31 years. Medications and injections have helped temporarily. The pain is now constant and getting worse, with a 3-4/10 severity with radiation into the legs, left worse than right. There is numbness and weakness and difficulty lifting his left leg up while walking. His left leg pain is worse than his back pain. Objective findings include decreased lumbar range of motion, antalgic gait, and weakness in the lower extremities. His right lower extremity has normal muscle strength but the left lower extremity has 4/5 strength. Reflexes are decreased but symmetric. Heel and toe walk are impaired. An MRI of the lumbar spine on 4/3/14 shows lateral recess stenosis at L4-5. EMG of the lower extremities on 11/1/13 shows bilateral S1 radiculopathy, worse on the left. Diagnostic impression: lumbar radiculopathy. Treatment to date: physical therapy, medications, brace, injections--all with some benefit reported in the distant past. A UR decision on 8/8/14 denied the request for L4-S1 decompression on the basis that there was no indication that physical therapy, manual therapy, psychological screening, and back school have been considered. The request for lumbar brace was denied on the basis that guidelines do not support the use of LSO braces beyond the acute phase of symptom relief. The requests for assistant surgeon, inpatient hospital stay, vascutherm DVT system, and pre-op medical clearance were denied because the surgical procedure was not certified.

### IMR ISSUES, DECISIONS AND RATIONALES

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

## **1 DECOMPRESSION AT L4-S1 @ [REDACTED]: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES, INDICATIONS FOR SURGERY

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Low Back Chapter.

**Decision rationale:** CA MTUS states that surgical intervention is recommended for patients who have severe and disabling lower leg symptoms in the distribution consistent with abnormalities on imaging studies (radiculopathy), preferably with accompanying objective signs of neural compromise; activity limitations due to radiating leg pain for more than one month or extreme progression of lower leg symptoms; clear clinical, imaging, and electrophysiologic evidence of a lesion that has been shown to benefit in both the short and long-term from surgical repair; and failure of conservative treatment. In the present case, there is compelling medical evidence to support L4-S1 lumbar decompression. The patient has subjective complaints consistent with radiculopathy and objective findings of weakness on physical exam that correlate with nerve root pathology on MRI and electrodiagnostic studies. However, it is not clear from the documentation exactly what types of conservative treatment have been provided and when, and what their effect was. It appears that it has been several years since any type of physical therapy has been done, and if this is the case then additional physical therapy would be recommended prior to recommending the proposed surgery. In addition, it appears that prior lumbar injections have been performed but it is not clear what type of injections these were, what dates they were given, and what their effect was. Overall, the extent, duration, and effect of prior conservative treatment modalities is not documented. Therefore, the request for 1 DECOMPRESSION AT L4-S1 @ [REDACTED] is not medically necessary.

## **1 ASSISTANT SURGEON: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation CENTERS FOR MEDICARE AND MEDICAID SERVICES, PHYSICIAN FEE SCHEDULE SEARCH

**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: American Academy of Orthopedic Surgeons (AAOS).

**Decision rationale:** CA MTUS and ODG do not address this issue. American Academy of Orthopaedic Surgeons Position Statement Reimbursement of the First Assistant at Surgery in Orthopaedics states on the role of the First Assistant: According to the American College of Surgeons: "The first assistant to the surgeon during a surgical operation should be a trained individual capable of participating and actively assisting the surgeon to establish a good working team. The first assistant provides aid in exposure, hemostasis, and other technical functions, which will help the surgeon carry out a safe operation and optimal results for the patient. The

role will vary considerably with the surgical operation, specialty area, and type of hospital. "The first assistant's role has traditionally been filled by a variety of individuals from diverse backgrounds. Practice privileges of those acting as first assistant should be based upon verified credentials reviewed and approved by the hospital credentialing committee (consistent with state laws)." In general, the more complex or risky the operation, the more highly trained the first assistant should be. Criteria for evaluating the procedure include:-anticipated blood loss - anticipated anesthesia time -anticipated incidence of intraoperative complications -procedures requiring considerable judgmental or technical skills -anticipated fatigue factors affecting the surgeon and other members of the operating team -procedures requiring more than one operating team. In limb reattachment procedures, the time saved by the use of two operating teams is frequently critical to limb salvage. It should be noted that reduction in costly operating room time by the simultaneous work of two surgical teams could be cost effective. In the present case, the complexity appears to warrant an assistant surgeon. However, the request cannot be approved because the surgical procedure was not certified. Therefore, the request for 1 assistant surgeon is not medically necessary.

**1 IN-PATIENT HOSPITAL STAY @ [REDACTED]: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES, HOSPITAL LENGTH OF STAY (LOS)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Low Back Chapter.

**Decision rationale:** CA MTUS does not address this issue. ODG recommends a 1-day hospital stay after uncomplicated lumbar decompression. Although the present request would normally be approved, it cannot at this time because the surgical procedure was not certified. Therefore, the request for 1 IN-PATIENT HOSPITAL STAY @ [REDACTED] is not medically necessary.

**1 LSO BRACE: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298 AND 301.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Low Back Chapter.

**Decision rationale:** CA MTUS states that lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief, however, ODG states that lumbar supports are not recommended for prevention; as there is strong and consistent evidence that lumbar supports were not effective in preventing neck and back pain. They are recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented

instability, and for treatment of nonspecific LBP as a conservative option. Since this patient has chronic pain and is not in the acute phase of symptom relief, the request cannot be certified. Therefore, the request for 1 LSO brace is not medically necessary.

**2 WEEK VASCUTHERM 4DVT SYSTEM W/HOT-COLD COMPRESSION:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 161.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Official Disability Guidelines (ODG): Knee and Leg Chapter. .

**Decision rationale:** CA MTUS does not address this issue. ODG states that continuous-flow cryotherapy is recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. However, ODG states that while there are studies on continuous-flow cryotherapy, there are no published high quality studies on the Game Ready device or any other combined system. In the present case, there is no rationale provided that identifies why a simple cryotherapy unit would be insufficient. In addition, there are no established risk factors for DVT in this patient. The surgical procedure was also not certified. Therefore, the request for 2 WEEK VASCUTHERM 4DVT SYSTEM W/HOT-COLD COMPRESSION is not medically necessary.

**1 PRE-OP MEDICAL CLEARANCE@ [REDACTED]:** Upheld

**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-LUMBAR & THORACIC (ACUTE AND CHRONIC)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): ODG (Low Back - Lumbar & Thoracic (Acute & Chronic) Chapter-Pre operative EKG and Lab testing. Other Medical Treatment Guideline or Medical Evidence: ACC/AHA 2007 Guidelines on perioperative cardiovascular evaluation and care for noncardiac surgery.

**Decision rationale:** CA MTUS does not address this issue. ODG states that pre-op testing can be helpful to stratify risk, direct anesthetic choices, and guide postoperative management, but often are obtained because of protocol rather than medical necessity. The decision to order preoperative tests should be guided by the patient's clinical history, comorbidities, and physical examination findings. Patients with signs or symptoms of active cardiovascular disease should be evaluated with appropriate testing, regardless of their preoperative status. Electrocardiography is recommended for patients undergoing high-risk surgery and those undergoing intermediate-risk surgery who have additional risk factors. Patients undergoing low-risk surgery do not require electrocardiography. Chest radiography is reasonable for patients at risk of postoperative pulmonary complications if the results would change perioperative management. The ACC/AHA 2007 Guidelines on perioperative cardiovascular evaluation and care for noncardiac surgery state that in the asymptomatic patient, a more extensive assessment of history and physical

examination is warranted in those individuals 50 years of age or older. In the present case, the request for preop clearance cannot be approved because the surgical procedure was not certified. Therefore, the request for 1 PRE-OP MEDICAL CLEARANCE@ [REDACTED] [REDACTED] is not medically necessary.