

Case Number:	CM15-0126667		
Date Assigned:	07/13/2015	Date of Injury:	05/09/2014
Decision Date:	08/06/2015	UR Denial Date:	06/16/2015
Priority:	Standard	Application Received:	06/30/2015

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: Iowa, Illinois, Hawaii

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & General Preventive Medicine

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 42-year-old male, who sustained an industrial injury on May 9, 2014. He reported feeling back pain and pain down his legs. The injured worker was diagnosed as having back pain, grade I L5 on S1 spondylolisthesis and disc displacement. Treatment to date has included diagnostic studies, physical therapy and medications. Notes stated that he had no improvement after the physical therapy. On June 11, 2015, the injured worker complained of low back pain. Physical examination of the lumbar spine revealed tenderness to palpation through the para lumbar muscles with spasms and guarding. The treatment plan listed a recommendation for spine surgery, a transcutaneous electrical nerve stimulation unit, medications and a follow-up visit. On June 16, 2015, Utilization Review non-certified the request for L5-S1 anterior lumbar interbody fusion with assistant surgeon, pre-op consult and DME cold therapy unit, citing California MTUS, ACOEM, Official Disability Guidelines and other citations.

IMR ISSUES, DECISIONS AND RATIONALES

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

IPSX L5-S1 anterior lumbar interbody fusion with assistant surgery: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

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 - Lumbar & Thoracic (Acute & Chronic), Fusion (spinal).

Decision rationale: ODG states, "For chronic low back problems, fusion should not be considered within the first 6 months of symptoms, except for fracture, dislocation or progressive neurologic loss. Indications for spinal fusion may include: (1) Neural Arch Defect; Spondylolytic spondylolisthesis, congenital neural arch hypoplasia. (2) Segmental Instability (objectively demonstrable); Excessive motion, as in degenerative spondylolisthesis, surgically induced segmental instability and mechanical intervertebral collapse of the motion segment and advanced degenerative changes after surgical discectomy, with relative angular motion greater than 20 degrees. (Andersson, 2000) (Luers, 2007) (3) Primary Mechanical Back Pain (i.e., pain aggravated by physical activity)/Functional Spinal Unit Failure/Instability, including one or two level segmental failure with progressive degenerative changes, loss of height, disc-loading capability. In cases of workers compensation, patient outcomes related to fusion may have other confounding variables that may affect overall success of the procedure, which should be considered. There is a lack of support for fusion for mechanical low back pain for subjects with failure to participate effectively in active rehab pre-op, total disability over 6 months, active psych diagnosis, and narcotic dependence. Spinal instability criteria includes lumbar inter-segmental movement of more than 4.5 mm. (Andersson, 2000) (4) Revision Surgery for failed previous operation(s) if significant functional gains are anticipated. Revision surgery for purposes of pain relief must be approached with extreme caution due to the less than 50% success rate reported in medical literature. (5) Infection, Tumor, or Deformity of the lumbosacral spine that cause intractable pain, neurological deficit and/or functional disability. (6) After failure of two discectomies on the same disc, fusion may be an option at the time of the third discectomy, which should also meet the ODG criteria. (See ODG Indications for Surgery; Discectomy.) Pre-Operative Surgical Indications Recommended: Pre-operative clinical surgical indications for spinal fusion should include all of the following: (1) All pain generators are identified and treated; & (2) All physical medicine and manual therapy interventions are completed; & (3) X-rays demonstrating spinal instability and/or myelogram, CT-myelogram, or discography (see discography criteria) & MRI demonstrating disc pathology correlated with symptoms and exam findings; & (4) Spine pathology limited to two levels; & (5) Psychosocial screen with confounding issues addressed. (6) For any potential fusion surgery, it is recommended that the injured worker refrain from smoking for at least six weeks prior to surgery and during the period of fusion healing. (Colorado, 2001) (BlueCross BlueShield, 2002) For average hospital LOS after criteria are met, see Hospital length of stay (LOS)." The medical documentation provided indicate this patient has been diagnosed with grade 1 spondylolisthesis, the treating physician has not provided documentation of instability, fracture or infection as outline in the guidelines above. As such, the request for IPSX L5-S1 anterior lumbar interbody fusion with assistant surgery is not medically necessary.

Related surgical service: Pre-operative 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 Official Disability Guidelines (ODG) Low back, Preoperative testing, General.

Decision rationale: The MTUS is silent on preoperative testing. The ODG states that: 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. Routine preoperative tests are defined as those done in the absence of any specific clinical indication or purpose and typically include a panel of blood tests, urine tests, chest radiography, and an electrocardiogram (ECG). These tests are performed to find latent abnormalities, such as anemia or silent heart disease, that could impact how, when, or whether the planned surgical procedure and concomitant anesthesia are performed. It is unclear whether the benefits accrued from responses to true-positive tests outweigh the harms of false-positive preoperative tests and, if there is a net benefit, how this benefit compares to the resource utilization required for testing. The medical records fail to demonstrate any clinical history making this patient at high risk as outlined in guidelines. The requested surgery has been non-certified; therefore, the necessity of the pre-operative clearance has not been established. As such, the request for related surgical service: Pre-operative consultation is not medically necessary.

Related surgical service: Cold therapy unit: 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 Official Disability Guidelines (ODG) Low Back (Lumbar and Thoracic), Lumbar Support and Other Medical Treatment Guidelines
<http://www.deroyal.com/medicalproducts/orthopedics/product.aspx?id=pc-temptherapy-coldtherunit>.

Decision rationale: MTUS is silent on the use of cold therapy units. ODG for heat/cold packs states: recommended as an option for acute pain. At-home local applications of cold packs in first few days of acute complaint; thereafter, applications of heat packs or cold packs. (Bigos, 1999) (Airaksinen, 2003) (Bleakley, 2004) (Hubbard, 2004) Continuous low-level heat wrap therapy is superior to both acetaminophen and ibuprofen for treating low back pain. (Nadler 2003) The evidence for the application of cold treatment to low-back pain is more limited than heat therapy, with only three poor quality studies located that support its use, but studies confirm that it may be a low risk low cost option. (French-Cochrane, 2006) There is minimal evidence supporting the use of cold therapy, but heat therapy has been found to be helpful for pain reduction and return to normal function. (Kinkade, 2007). The uses of devices that continually circulate a cooled solution via a refrigeration machine have not been shown to provide a significant benefit over ice packs. Additionally, the requested surgical procedure has been non-certified; therefore the medical necessity of this request has not been established. As such the request for related surgical service: Cold therapy unit is not medically necessary.