

<b>Case Number:</b>	CM15-0176009		
<b>Date Assigned:</b>	09/17/2015	<b>Date of Injury:</b>	06/07/2011
<b>Decision Date:</b>	10/29/2015	<b>UR Denial Date:</b>	08/26/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/08/2015

### 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: California

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 57 year old male, who sustained an industrial injury on 06-07-2011. Work status not noted in received medical records. Medical records indicated that the injured worker is undergoing treatment for chronic lumbar pain, lumbar radiculopathy, exacerbated cervical pain, and cervical radiculopathy. Treatment and diagnostics to date has included lumbar spine MRI and medications. Current medications include Tylenol #3, Gabapentin, Docuprene, Ambien, and Prevacid. Per 06-02-2015 progress report, MRI of the lumbar spine dated 05-04-2015 "re-demonstrates moderate anterior wedging of the L1 vertebral body, unchanged compared to the previous examination", at the level L4-L5, there is 1mm posterior disc bulge with mild narrowing", "mild bilateral neural foraminal narrowing", "at level L5-S1, mild disc narrowing is noted with 4mm broad-based disc protrusion and left lateral recess with annular tearing-decrease in seize compared to previous examination", "unchanged mild to moderate narrowing of the midline thecal sac", "severe narrowing of the left lateral recess with most likely impingement of the left S1 nerve root unchanged", and "mild to moderate left and mild right neural foraminal narrowing". In a progress note dated 07-27-2015, the injured worker reported chronic low back and neck pain with lower extremity symptoms. Objective findings included spasm and tenderness of the lumbar spine with decreased range of motion, normal cervical spine range of motion with pain in all directions, and deep tendon reflexes and motor examination are within normal limits with decreased sensation noted over the C6 and C7 distribution bilaterally. The request for authorization dated 08-07-2015 requested post fusion and gill laminectomy with pedicle screws at L5-S1, preoperative medical clearance, assistant surgeon, intraoperative monitoring, two day hospitalization, postoperative TENS (Transcutaneous Electrical Nerve Stimulation) Unit 3-5x day for 3-9 months, postoperative cryotherapy 3-5x day for 3-9 months,

and postoperative lumbar brace. The Utilization Review with a decision date of 08-26-2015 non-certified the request for 2 day inpatient surgery-post fusion and gill laminectomy at L5-S1 with assistant surgeon and intraoperative monitoring, postoperative TENS (Transcutaneous Electrical Nerve Stimulation) Unit 3-5x per day for 3-9 months, postoperative cryotherapy unit 3-5x day for 3-9 months, lumbar brace for postoperative use, and pre-operative medical clearance.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **2 day Inpatient surgery; Post Fusion & Gill Laminectomy at L5-S1 with Assistant Surgeon and Intraoperative Monitoring: Overturned**

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines.

**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 Hospital length of stay.

**Decision rationale:** CA MTUS/ACOEM is silent on the issue of hospital length of stay following a lumbar fusion. According to the ODG, Low back section, Hospital length of stay, a 3 day inpatient stay is recommended following an posterior lumbar fusion. As a request is for 2 days the determination is for certification as medically necessary and appropriate.

#### **Post Operative TENS Unit 3-5x per day for 3-9 months: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

**Decision rationale:** According to the California MTUS Chronic Pain Medical Treatment Guideline regarding TENS, pages 113-114, chronic pain (transcutaneous electrical nerve stimulation), not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration, for neuropathic pain and CRPS II and for CRPS I (with basically no literature to support use). Criteria for the use of TENS: Chronic intractable pain (for the conditions noted above): Documentation of pain of at least three months duration. There is evidence that other appropriate pain modalities have been tried (including medication) and failed. A one-month trial period of the TENS unit should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function; rental would be preferred over purchase during this trial. In this case there is insufficient evidence of chronic neuropathic pain from the exam note of 7/27/15 to warrant a TENS unit. There also is no evidence of a evidence based functional restoration plan. Therefore, the determination is for non-certification. The request is not medically necessary.

#### **Post-operative Cryotherapy Unit 3-5x day for 3-9 months: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (20th Annual Edition) Low Back Chapter.

**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, Continuous flow cryotherapy.

**Decision rationale:** CA MTUS/ACOEM is silent on the issue of continuous flow cryotherapy. According to the ODG Low Back section, cold/heat packs is recommended as an option for acute pain. It is recommended for at home application of cold packs for the first few days of acute complaint. The ODG does not recommend continuous flow cryotherapy as cold packs is a low risk cost option. Therefore the determination is for non-certification. The request is not medically necessary.

**Post operative Lumbar Brace:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (20th Annual Edition) Low Back Chapter.

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Initial Care.

**Decision rationale:** CA MTUS/ACOEM is silent on postoperative lumbar bracing. According to ODG, back brace, postoperative, do not demonstrate the medical necessity for lumbar bracing after lumbar surgery. The medical records do not document that this patient has fracture or instability. Current medical literature does not demonstrate improved outcomes with bracing after lumbar surgery. There is no documentation of fracture, instability or any condition that would support guideline for lumbar bracing. Postoperative lumbar bracing is not medically necessary and not supported by existing Official Disability Guidelines criteria in cases without documented instability or fracture. Therefore, this request is not medically necessary.

**Pre-operative Medical Clearance:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (20th Annual Edition).

**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.

**Decision rationale:** CA MTUS/ACOEM is silent on the issue of preoperative clearance and testing. ODG, Low back, Preoperative testing general, is utilized. This chapter states that preoperative testing is guided by the patient's clinical history, comorbidities and physical examination findings. ODG states, "These investigations 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. Based on the information provided for review, there is no indication of any of these clinical scenarios present in this case. In this case the patient is a healthy 57 year old without comorbidities or physical examination findings concerning to warrant preoperative testing prior to the proposed surgical procedure. Therefore the determination is for non-certification. The request is not medically necessary.