

Case Number:	CM14-0009631		
Date Assigned:	05/12/2014	Date of Injury:	09/14/2000
Decision Date:	07/25/2014	UR Denial Date:	12/18/2013
Priority:	Standard	Application Received:	01/24/2014

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 Surgery, 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 58-year-old male patient with a 9/14/00 date of injury. 2/27/14 progress report indicates persistent marked difficulties with activities of daily living secondary to neck and back pain, and diminished upper and lower extremity function. Transitioning out of a seat into a standing position requires significant manipulation with his arms and he uses braces or a chair to propel himself on. The current complaints are specific for low back pain radiating to the left leg into the left foot. The patient is on medication for diabetes, arthritis, and hypertension. He has undergone previous right total hip arthroplasty on 12/15/1997, and right knee arthroscopy in 1976. The patient underwent left total hip arthroplasty with subtrochanteric femorosteotomy and bone grafting on 8/3/12. The patient is obese at 5 feet 8 inches and 290 pounds. Physical exam demonstrates marked deformity of the upper extremities and joints secondary to arthritis. There is limited cervical range of motion, bilateral iliopsoas weakness, unremarkable lower extremity motor and sensory exam. The patient's gait is markedly antalgic. The patient has marked lumbar levoscoliosis. 8/8/13 lumbar MRI demonstrates significant central canal stenosis at L1-2 and L4-5 secondary to degenerative joint disease and hypertrophy of ligamentum flavum; with severe thoracolumbar degenerative disc and joint disease, resulting in degenerative levoscoliosis; with borderline lumbar stenosis at L5-S1. Discussion identifies that given the severity of his cervical disk and joint disease, the patient would have to undergo cervical decompression first; followed by L1-2 and L4-5 laminectomy in the future once he has recovered from the cervical spine operation. The cervical spine condition and need for cervical surgery is described as a stumbling block in moving forward and proceeding with lumbar spine surgery. Discussion identifies that L1-2 and L4-5 laminectomy is planned to simply decompress the spinal canal. 2/5/14 lower extremity EMG demonstrates bilateral chronic cervical and lumbosacral polyradiculopathy. 7/23/13 progress report indicates forward stooped posture and persistent low back pain, with

easy fatigability of both legs secondary to lumbar stenosis. 8/1/13 progress report indicates unchanged physical exam findings. 9/26/13 progress report indicates persistent neck and low back pain radiating into the left and right leg. The most recent hip surgery has improved his complaints, with remaining issues as pain worsenes with standing or flexing forward when sitting down. 10/2/13 progress report indicates a fall the day before. 10/24/13 progress report indicates significant low back and leg pain. 11/5/13 progress report indicates unchanged complaints. 12/5/13 progress report indicates persistent lumbar stenosis; the patient recently fell and had an exacerbation in his symptoms. Physical exam demonstrates bilateral iliopsoas weakness and unremarkable lower extremity neurologic findings. The patient suffers from neurogenic claudication secondary to multilevel stenosis as per the requesting provider's discussion. While the most recent physical exam did not corroborate the diagnosis, earlier reports established easy fatigability of both legs secondary to lumbar stenosis that was not recently observed. Specifically, bowel or bladder dysfunction was not observed and listed as pertinent negative. Treatment to date has included chiropractic care, acupuncture, medication, physical therapy, aqua therapy, series of lumbar epidural injections, and activity modification. There is documentation of a previous 12/18/13 adverse determination as there was significant pathology at L4-5 and L5-S1 on lumbar MRI; and the clinical exam did not indicate that the L4-5 level would be significant for the requested surgery.

IMR ISSUES, DECISIONS AND RATIONALES

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

L1-L2 AND L4-L5 LAMINECTOMY: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-310. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Decompression Other Medical Treatment Guideline or Medical Evidence.

Decision rationale: CA MTUS states that spinal stenosis usually results from soft tissue and bony encroachment of the spinal canal and nerve roots. It has a gradual onset and usually manifests as a degenerative process after age 50. Evidence does not currently support a relationship with work. The surgical treatment for spinal stenosis is usually complete laminectomy. Surgery is rarely considered in the first three months after onset of symptoms, and a decision to proceed with surgery should not be based solely on the results of imaging studies. The patient presents with persistent low back pain and markedly antalgic gait attributed to neurogenic claudication. 8/8/13 lumbar MRI demonstrates significant central canal stenosis at L1-2 and L4-5 secondary to degenerative joint disease and hypertrophy of ligamentum flavum. Treatment to date has included chiropractic care, medication, physical therapy, and activity modification. However, CA MTUS states that elderly patients with spinal stenosis who tolerate their daily activities usually do not require surgery unless bowel or bladder dysfunction develops. Bladder and bowel symptoms were specifically reported as negative. While the patient does have some restrictions with ADLs, there are significant comorbidities that dilute differential diagnostic assessment as there is pronounced arthritis, bilateral hip replacements and obesity.

There remains concern about proposed levels as imaging findings are non-specific to the specific levels requested. Physical exam findings consistent with neurogenic claudication were not reported. Therefore, the request for L1-L2 and L4-L5 Laminectomy was not medically necessary.

PRE-OP 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 (ODG).

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 preoperative cardiovascular evaluation and care for noncardiac surgery.

Decision rationale: 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. However, there is no definition of the specific services requested. In addition, the associated request for L1-L2 AND L4-L5 LAMINECTOMY was deemed not medically necessary; therefore, the associated request for a pre-op medical clearance is also not medically necessary.

24 VISITS OF POST-OP PHYSICAL THERAPY FOR THE LUMBAR SPINE: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

Decision rationale: CA MTUS 2009: 9792.24.3. Postsurgical Treatment Guidelines support up to 16 postoperative PT visits. The associated request for L1-L2 AND L4-L5 LAMINECTOMY was deemed not medically necessary; therefore, the associated request for 24 VISITS OF POST-OP PHYSICAL THERAPY FOR THE LUMBAR SPINE is also not medically necessary.

PSYCHOLOGIST/PSYCHIATRIC EVALUATION: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: While the patient was deemed a candidate for the proposed decompressive surgery, psychological clearance is required for fusion surgery only. In the absence of a specific identified rationale for a psychologist evaluation, a psychologist evaluation is not indicated. Therefore, the request for PSYCHOLOGIST/PSYCHIATRIC EVALUATION is not medically necessary.