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| Case Number: | CM14-0132113 | | |
| Date Assigned: | 08/22/2014 | Date of Injury: | 04/14/2010 |
| Decision Date: | 09/23/2014 | UR Denial Date: | 08/11/2014 |
| Priority: | Standard | Application Received: | 08/18/2014 |

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 47 year old male with a 4/14/10 injury date. The mechanism of injury was a fall while shoveling dirt in the hopper of his dump truck. In a 7/25/14 follow-up, subjective complaints include progressive right-sided lower back pain, leg weakness causing previous falls, right lower extremity numbness, occasional right foot "slapping" during ambulation, and numbness and tingling radiating down both legs to the feet, worse on the right side. Objective findings include antalgic gait pattern with decreased lumbar range of motion, decreased sensation in the L3, L4, and S1 dermatomes on the right. Tibialis anterior and EHL are 4/5 strength on the right and inverters are 4+/5 on the right. Plantar flexors and everters on the right are 5-/5 on the right. There is global hyperreflexia. Straight leg raise on the right is positive at 60 degrees and elicits pain with radiation down the right leg to the distal calf. EMG/NCS on 5/19/14 was normal. A lumbar spine MRI on 7/12/14 showed multilevel degenerative disc disease and facet arthropathy with retrolisthesis of L4-5 and L5-S1. There was moderate to severe central stenosis at L4-5 with bilateral foraminal narrowing. At L5-S1, there was severe right foraminal narrowing and moderate left foraminal narrowing. A 9/19/12 orthopedic QME (qualified medical examiner) diagnosed the patient with a lumbosacral strain after essentially a normal physical exam. It was felt that the bulk of the symptoms did not correlate with significant physical abnormalities on examination. A 3/12/14 orthopedic QME reevaluation found maximal medical improvement and felt the patient would not improve from any further care other than a functional restoration program. It was noted during the exam that the patient had multiple embellished complaints of pain, with positive Gowey's sign and positive Waddell's non-structural signs throughout the exam. Diagnostic impression: lumbar disc herniation, lumbar radiculopathy. Treatment to date: pain management with meds, chiropractic care, acupuncture, and injections. A UR decision on 8/11/14 denied the request for microlumbar decompressive surgery on the right at L4-5 and L5-

S1 on the basis that the clinical findings documented by the requesting surgeon significantly differ from the Orthopaedic QME and are greatly in excess of what would be expected given the MRI findings.

IMR ISSUES, DECISIONS AND RATIONALES

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

Microlumbar decompressive surgery on the right L4-5 and L5-S1, with in the medical provider network: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 305-307.
Decision based on Non-MTUS Citation ODG.

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, the patient has inconsistent exam findings over time and evidence of malingering. His symptoms appear out of proportion to his imaging findings on the MRI and his normal EMG. The clinical findings and recommendations were in near complete opposition between the two orthopedic QMEs and the evaluations from the primary treating physician. Performing lumbar spine surgery at this time is very unlikely to produce an improved outcome for this patient. Therefore, the request for Microlumbar decompressive surgery on the right L4-5 and L5-S1, within the medical provider network is not medically necessary.

Medicine consult pre-operative: 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).

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. However, since the primary procedure is not medically necessary, none of the associated services are medically necessary. Therefore, the request for medicine consult pre-operative is not medically necessary.

EKG: 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 Other Medical Treatment Guideline or Medical Evidence: American Society of Anesthesiologists Practice Advisory for Preanesthesia Evaluation.

Decision rationale: CA MTUS and ODG do not address this issue. The American Society of Anesthesiologists states that routine preoperative tests (i.e., tests intended to discover a disease or disorder in an asymptomatic patient) do not make an important contribution to the process of perioperative assessment and management of the patient by the anesthesiologist; selective preoperative tests (i.e., tests ordered after consideration of specific information obtained from sources such as medical records, patient interview, physical examination, and the type or invasiveness of the planned procedure and anesthesia) may assist the anesthesiologist in making decisions about the process of perioperative assessment and management. However, since the primary procedure is not medically necessary, none of the associated services are medically necessary. Therefore, the request for EKG is not medically necessary.

Chest X-ray: 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 Other Medical Treatment Guideline or Medical Evidence: American Society of Anesthesiologists Practice Advisory for Preanesthesia Evaluation.

Decision rationale: CA MTUS and ODG do not address this issue. The American Society of Anesthesiologists states that routine preoperative tests (i.e., tests intended to discover a disease or disorder in an asymptomatic patient) do not make an important contribution to the process of perioperative assessment and management of the patient by the anesthesiologist; selective

preoperative tests (i.e., tests ordered after consideration of specific information obtained from sources such as medical records, patient interview, physical examination, and the type or invasiveness of the planned procedure and anesthesia) may assist the anesthesiologist in making decisions about the process of perioperative assessment and management. However, since the primary procedure is not medically necessary, none of the associated services are medically necessary. Therefore, the request for Chest x-ray is not medically necessary.

Pre-op labs: 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 Other Medical Treatment Guideline or Medical Evidence: American Society of Anesthesiologists Practice Advisory for Preanesthesia Evaluation.

Decision rationale: CA MTUS and ODG do not address this issue. The American Society of Anesthesiologists states that routine preoperative tests (i.e., tests intended to discover a disease or disorder in an asymptomatic patient) do not make an important contribution to the process of perioperative assessment and management of the patient by the anesthesiologist; selective preoperative tests (i.e., tests ordered after consideration of specific information obtained from sources such as medical records, patient interview, physical examination, and the type or invasiveness of the planned procedure and anesthesia) may assist the anesthesiologist in making decisions about the process of perioperative assessment and management. However, since the primary procedure is not medically necessary, none of the associated services are medically necessary. Therefore, the request for pre-op labs is not medically necessary.

Pain management follow ups: 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): Pain (chronic).

Decision rationale: CA MTUS does not address this issue. ODG states that outpatient pain rehabilitation programs may be considered medically necessary in the following circumstances: (1) The patient has a chronic pain syndrome, with evidence of loss of function that persists beyond three months and has evidence of three or more of the following: (a) Excessive dependence on health-care providers, spouse, or family; (b) Secondary physical deconditioning due to disuse and/or fear-avoidance of physical activity due to pain; (c) Withdrawal from social activities or normal contact with others, including work, recreation, or other social contacts; (d) Failure to restore preinjury function after a period of disability such that the physical capacity is insufficient to pursue work, family, or recreational needs; (e) Development of psychosocial sequelae that limits function or recovery after the initial incident, including anxiety, fear-

avoidance, depression, sleep disorders, or nonorganic illness behaviors (with a reasonable probability to respond to treatment intervention); (f) The diagnosis is not primarily a personality disorder or psychological condition without a physical component; (g) There is evidence of continued use of prescription pain medications (particularly those that may result in tolerance, dependence or abuse) without evidence of improvement in pain or function. However, since the primary procedure is not medically necessary, none of the associated services are medically necessary. Therefore, the request for pain management follow-ups is not medically necessary.