

Case Number:	CM15-0213500		
Date Assigned:	11/03/2015	Date of Injury:	11/17/2005
Decision Date:	12/24/2015	UR Denial Date:	10/01/2015
Priority:	Standard	Application Received:	10/30/2015

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: Illinois, California, Texas
 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:

This injured worker is a 69-year-old male who sustained an industrial injury on 11/17/05. Injury was sustained when his chair broke, and he fell backwards against a wall, striking his head. Past medical history was positive for prostate cancer, gastroesophageal reflux disease, diabetes, hyperlipidemia, depression, and sleep apnea. Records documented issues with post-traumatic headaches and memory loss. The 7/20/15 lumbar spine MRI impression documented a 5x4 mm intradural enhancing lesion within the thecal sac along the posterior right paramedian aspect at the L1/2. This could represent ependymoma with other differentials including meningioma, paraganglioma, etc. At L3/4, there was severe degenerative disc disease, with marked desiccation and decreased disc height, discogenic endplate changes, and anterior spur formation. There was severe central canal and moderate to severe bilateral neuroforaminal stenosis secondary to ligamentum flavum thickening. There was diffuse bulging of the disc osteophyte complex and moderate to severe facet arthropathy. At L4/5, there was degenerative disc disease with left-sided decreased disc height, discogenic endplate changes, and anterior spur formation, and disc desiccation. There was moderate to severe left and mild right neuroforaminal stenosis, and severe central canal stenosis secondary to marked ligamentum flavum thickening. There were diffuse bulges with caudal and cephalad extrusion of the central component and severe bilateral facet arthropathy. At L5/S1, there was diffuse disc bulging and left far posterolateral bulging, ligamentum flavum thickening, moderate bilateral facet arthropathy, mild central canal stenosis, and moderate to severe left neuroforaminal stenosis that appeared to impinge the left L5 nerve root. The 8/20/15 lower extremity electrodiagnostic study was reported abnormal with

electrodiagnostic evidence of mild sensorimotor polyneuropathy with predominantly axonal features. There was no electrodiagnostic evidence of a left lumbosacral radiculopathy. The 9/1/15 spine surgeon report cited complaints of moderate to severe neck and low back and gluteal pain associated with a recent history of balance problems, falls and weakness in the legs. He had reported an increase in his neck pain associated with headaches 2-3 times per week, and on-going low back with now onset lower extremity weakness. Symptoms were aggravated with standing and improved with walking. He had previous multiple epidural steroid injection, now these are not indicated due to his diabetes. Physical exam documented normal gait, close to normal upper and lower extremity strength, and numbness below the knees. The 9/8/15 cervical spine MRI impression documented cervical kyphosis and multilevel cervical spine alignment abnormalities. There was multilevel severe spinal canal stenosis with cord compression predominantly at C3/4 and C4/5, and multilevel severe neuroforaminal stenosis. There was a 4 mm spondylolisthesis of C3 on C4 and C4 on C5. The 9/17/15 spine surgery report documented a diagnosis of degenerative scoliosis L3 through L5, neurogenic claudication and radiculopathy, and multilevel cervical disc degeneration C3 through T1 with cervical kyphosis. He had a history of progressive grip strength loss, loss of upper extremity coordination, numbness in the upper and lower extremities, loss of balance, and generalized fatigue. Imaging was reviewed. Surgical intervention for the surgical spine was recommended. He will require a lumbar laminectomy and fusion at a later date, but the cervical spine is a priority. The 9/21/15 treating physician report cited increasing neck and back pain associated with bilateral upper and lower extremity numbness and tingling. The injured worker was proceeding with cervical spine surgery and holding off on lumbar spine surgery for now. Cervical spine exam documented paraspinal spasms and guarding, positive Spurling's test, and decreased range of motion. Lumbar spine exam was reported as unchanged. The treating physician documented agreement with spine surgeon to proceed with cervical spine surgery prior to lumbar surgery. A urology consult was recommended. A neurology consult was recommended given the injured worker's continued head trauma issues with neurologic deficits and worsening urinary incontinence issues. Authorization was requested for anterior cervical discectomy and fusion C3-C5, urology consult, neurology consult, cardiac clearance, and lumbar spine decompression and fixation L3-L5 (at a later date). The 9/28/15 psychiatric report indicated that this injured worker suffered from major depressive disorder, severe with high level of anxiety, and psychological factors affecting his medical condition. He was taking psychotropic medications. He had also been prescribed Myrbetreq for his overactive bladder, but this request would be deferred to the urologist. The 10/1/15 utilization review certified the request for C3-C5 anterior cervical discectomy and fusion. The additional requests urology consult, neurology consult, cardiac clearance, and lumbar spine decompression and fixation L3-L5 were non-certified. The rationale stated that as the requested surgical procedure was not medically necessary, none of the associated services were medically necessary and appropriate.

IMR ISSUES, DECISIONS AND RATIONALES

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

Urology consult, Qty 1: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Occupational Medicine Practice

Guidelines, 2nd edition 2004, Chapter 7: Independent Medical Examinations and Consultations, pages 127.

MAXIMUS guideline: Decision based on MTUS General Approaches 2004, Section(s): Cornerstones of Disability Prevention and Management. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Independent Medical Examinations and Consultations, page(s) 127.

Decision rationale: The California MTUS guidelines state that referrals may be appropriate if the practitioner is uncomfortable with treating a particular cause of delayed recovery. The ACOEM guidelines support referral to a specialist if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. A consultant is usually asked to act in an advisory capacity, but may sometimes take full responsibility for treatment of a patient. Guideline criteria have been met. This injured worker has a complex urological history with prior prostatectomy and worsening urinary incontinence. Medications have been prescribed for an overactive bladder. A urology consult is medically appropriate and reasonable to assist in the management of this case. Therefore, this request is medically necessary.

Neurology consult, Qty 1: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Occupational Medicine Practice Guidelines, 2nd edition 2004, Chapter 7: Independent Medical Examinations and Consultations, pages 127.

MAXIMUS guideline: Decision based on MTUS General Approaches 2004, Section(s): Cornerstones of Disability Prevention and Management.

Decision rationale: The California MTUS guidelines state that referrals may be appropriate if the practitioner is uncomfortable with treating a particular cause of delayed recovery. The ACOEM guidelines support referral to a specialist if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. A consultant is usually asked to act in an advisory capacity, but may sometimes take full responsibility for treatment of a patient. Guideline criteria have been met. This injured worker has a history of head trauma with on-going symptoms of memory loss and neurologic deficits. This request is reasonable to address on-going neurologic issues and delayed recovery. Therefore, this request is medically necessary.

Cadiac clearance, Qty 1: 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 - Preoperative testing, general.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Institute for Clinical Systems Improvement (ICSI). Preoperative evaluation. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2010 Jun. 40 p.

Decision rationale: The California MTUS guidelines do not provide recommendations for this service. Evidence based medical guidelines state pre-anesthesia cardiac evaluation may include consultation with specialists and ordering, requiring, or performing tests that range from noninvasive passive or provocative screening tests (e.g., stress testing) to noninvasive and invasive assessment of cardiac structure, function, and vascularity (e.g., echocardiogram, radionucleotide imaging, cardiac catheterization). Guideline criteria have not been met. A generic request for pre-operative cardiac clearance is under consideration. Consultation with a specialist and or cardiac testing may be indicated based on patient age and co-morbidities. However, the request is non-detailed and the associated surgical procedure is not supported. Therefore, this request is not medically necessary.

Lumbar spine decompression and fixation between L3 and L5 (at a later date), Qty 1:
Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004.

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, Discectomy/Laminectomy, Fusion (spinal).

Decision rationale: The California MTUS recommend surgical consideration when there is severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies (radiculopathy), preferably with accompanying objective signs of neural compromise. Guidelines require clear clinical, imaging and electrophysiologic evidence of a lesion that has been shown to benefit both in the short term and long term from surgical repair. The guidelines recommend that clinicians consider referral for psychological screening to improve surgical outcomes. The Official Disability Guidelines recommend criteria for lumbar discectomy that include symptoms/findings that confirm the presence of radiculopathy and correlate with clinical exam and imaging findings. Guideline criteria include evidence of nerve root compression, imaging findings of nerve root compression, lateral disc rupture, or lateral recess stenosis, and completion of comprehensive conservative treatment. The Official Disability Guidelines do not recommend lumbar fusion for patients with degenerative disc disease, disc herniation, spinal stenosis without degenerative spondylolisthesis or instability, or non-specific low back pain. Fusion may be supported for segmental instability (objectively demonstrable) including excessive motion, as in isthmic or degenerative spondylolisthesis, surgically induced segmental instability and mechanical intervertebral collapse of the motion segment and advanced degenerative changes after surgical discectomy. Spinal instability criteria includes lumbar inter- segmental translational movement of more than 4.5 mm. Pre-operative clinical surgical indications require completion of all physical therapy and manual therapy interventions, x-rays demonstrating spinal instability and/or imaging demonstrating nerve root impingement correlated with symptoms and exam findings, spine fusion to be performed at 1 or 2 levels,

psychosocial screening with confounding issues addressed, and smoking cessation for at least 6 weeks prior to surgery and during the period of fusion healing. Guideline criteria have not been met. This injured worker presents with low back pain radiating into the buttocks with bilateral lower extremity numbness and tingling. Evidence of long-term reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. However, the current clinical exam findings do not evidence neurologic deficits correlated with imaging evidence of severe degenerative disc disease and stenosis. There is no radiographic evidence of spondylolisthesis or spinal segmental instability on flexion and extension x-rays. There is no discussion supporting the need for wide decompression that would result in temporary intraoperative instability and necessitate fusion. Potential psychological issues are documented with no evidence of a psychological clearance for surgery. Therefore, this request is not medically necessary at this time.