

Case Number:	CM15-0050689		
Date Assigned:	03/24/2015	Date of Injury:	04/16/2007
Decision Date:	05/06/2015	UR Denial Date:	02/25/2015
Priority:	Standard	Application Received:	03/17/2015

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:

The injured worker is a 52-year-old male who sustained an industrial injury on 4/16/07. The mechanism of injury was not documented. Past medical history was positive for depression and gastrointestinal bleeding likely due to non-steroidal anti-inflammatory drug use. The 4/18/12 cervical spine MRI impression documented slight progression of C4/5 changes now with effacement of the CSF space dorsally as well as indentation of the ventral thecal sac. There were multilevel, multifactorial changes of the cervical spine with neuroforaminal stenosis. There were anterior disc osteophyte complex, loss of disc height, and disc desiccation with endplate irregularity at C5/6 and C6/7. The 4/18/12 cervical x-rays documented degenerative changes from C3/4 to C6/7. There was minimal retrolisthesis of C4 on C5. The 2/16/15 treating physician report cited continued moderate to severe cervical pain with left upper extremity radiculopathy that was very limiting. Physical examination documented cervical tenderness and spasms, left upper extremity dysesthesias to the radial forearm, left triceps and brachioradialis hyporeflexia, positive left Spurling's test, and normal gait. MRI findings showed spondylosis throughout the cervical spine. There was a large central disc herniation at C4/5 that indented the thecal sac and abutted the cord with some collapse at this level. There was a left C6/7 disc herniation and T1/2 central disc herniation. The most recent flexion/extension x-rays showed good mobility at C4/5 but near ankyloses at C5/6 and C6/7. The diagnosis was cervical intervertebral disc displacement without myelopathy, cervical intervertebral disc degeneration, and cervical intervertebral disc disorder with myelopathy. Authorization was requested for C4/5 total disc arthroplasty and associated surgical services, including pre-operative medical clearance, EKG, and lab work

(complete blood count with differential, comprehensive metabolic panel, prothrombin time, partial thromboplastin time, and urinalysis). The 2/25/15 utilization review non-certified the request for pre-operative medical clearance, EKG, and lab work (CBC, CMP, PT/PTT, and UA) as the associated surgery was not medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

Pre op medical clearance with EKG and pre op-labs (CBC with diff, CMP, PT, PTT, UA):
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 Practice advisory for preanesthesia evaluation: an updated report by the American Society of Anesthesiologists Task Force on Preanesthesia Evaluation. *Anesthesiology* 2012 Mar; 116(3):522-38.

Decision rationale: The California MTUS guidelines do not provide recommendations for pre-operative medical clearance, EKG or lab work. Evidence based medical guidelines indicate that a basic pre-operative assessment is required for all patients undergoing diagnostic or therapeutic procedures. Guidelines indicate that most laboratory tests are not necessary for routine procedures unless a specific indication is present. Indications for such testing should be documented and based on medical records, patient interview, physical examination, and type and invasiveness of the planned procedure. EKG may be indicated for patients with known cardiovascular risk factors or for patients with risk factors identified in the course of a pre-anesthesia evaluation. In this case, the request for pre-operative medical clearance, EKG, and lab work (complete blood count with differential, comprehensive metabolic panel, prothrombin time, partial thromboplastin time, and urinalysis) would be reasonable based on the patient's age, history of bleeding, magnitude of surgical procedure, recumbent position, fluid exchange, and the risks of undergoing anesthesia. However, the medical necessity of the associated surgical request for artificial disc replacement in view of multilevel degenerative disc disease has not been established. Therefore, this request is not medically necessary.