

| | | | |
|-----------------------|--------------|------------------------------|------------|
| Case Number: | CM15-0083889 | | |
| Date Assigned: | 05/06/2015 | Date of Injury: | 08/09/2013 |
| Decision Date: | 06/05/2015 | UR Denial Date: | 04/27/2015 |
| Priority: | Standard | Application Received: | 05/01/2015 |

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 53-year-old male who sustained an industrial injury on 8/9/13. He reported a low back injury relative to repetitive heavy lifting. Conservative treatment included medications, physical therapy, multiple injections, medications, and weight loss without sustained improvement. Past medical history was positive for hypertension and hypercholesterolemia. Social history documented that the patient smoked 1½ packs of cigarettes per day. The 1/21/14 bilateral lower extremity electro diagnostic study was reported as abnormal with findings consistent with chronic L5 nerve root irritation on the right side. The 3/19/15 lumbar spine MRI impression documented L4/5 moderate left neuroforaminal stenosis with deformity of the exiting L4 nerve root, and multifactorial degenerative changes at L5/S1 including a left-sided synovial cyst resulting in moderate neuroforaminal stenosis that compressed the existing bilateral L5 nerve roots. There was laterally directed disease mildly effacing the exiting left L2 and bilateral L5 nerve roots and extraforaminal zones. There was edema signal within the bilateral L4 and L5 pedicles, right greater than left, likely reflecting a stress reaction. The 3/31/15 treating physician report cited constant grade 8/10 back and leg pain that had persisted despite conservative treatment. He had difficulty with most activities of daily living. Physical exam documented a significant forward lean posture, lumbar paraspinal muscle tenderness, antalgic gait with heel/toe walking on the right, and positive straight leg raise. Neurologic exam documented 4+/5 right extensor hallucis longus weakness, decreased right L5 dermatomal sensation, patellar reflexes +1 and Achilles reflexes absent. MRI showed degenerative disc disease at L3/4, L4/5, and L5/S1 with facet arthropathy, lateral recess and

foraminal stenosis, right greater than left. The treatment plan recommended decompression, fusion and stabilization from L3-S1 with laminectomy, nerve root decompression, posterior pedicle screw fixation from L3-S1, and transforaminal lumbar interbody fusion from L3-S1 along with posterolateral fusion using local and allograft bone and bone marrow aspirate supplement. The 4/24/15 utilization review non-certified a request for pre-op cardiac clearance and pre-op lab work as the associated surgical request for multilevel lumbar fusion was not found medically necessary. The 4/28/15 treating physician appeal letter documented lumbar spine x-rays that showed multilevel degenerative changes at L3/4, L4/5, and L5/S1, with retrolisthesis of L3 on L4, and multilevel facet arthropathy with osteophytic formation at L3/4, L4/5, and L5/S1. The treating physician opined the injured worker would require a complete laminectomy and facetectomy to address his lateral recess and foraminal stenosis, which would create temporary intraoperative instability. Authorization was requested for decompression and fusion from L3-S1.

IMR ISSUES, DECISIONS AND RATIONALES

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

Pre-op cardiac clearance/pre-op lab work: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, Chapter 7: Independent Medical Examinations and Consultations, page 127.

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 this service. 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. Guideline criteria for cardiac clearance would be met based on patient age, magnitude of the surgical procedure, history of smoking, comorbidities, and the risk of anesthesia, if the associated surgery was found medically necessary. Although basic lab testing is typically supported for patients of similar age and comorbidities, the medical necessity of the non-specific pre-op lab work requested could not be established. Therefore, this request is not medically necessary.