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| Case Number: | CM14-0148981 | | |
| Date Assigned: | 09/18/2014 | Date of Injury: | 12/01/2012 |
| Decision Date: | 11/19/2014 | UR Denial Date: | 08/26/2014 |
| Priority: | Standard | Application Received: | 09/12/2014 |

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 64 year old female with a 12/1/12 injury date. She tripped and fell and injured her lower back. The medical records were reviewed. In a follow-up on 9/19/14, subjective complaints included lower back pain with left leg radiation. Objective findings included tenderness over the left side of the lumbar paraspinals, restricted lumbar range of motion, positive straight-leg-raising at 90 degrees on the left leg, numbness and tingling in her left calf, and no motor/sensory/reflex deficits. A lumbar spine MRI (date not provided) is reported by the provider to show L4-5 disc protrusion with a broad-based lumbar disk protrusion causing stenosis more to the left than the right. Diagnostic impression: lumbar stenosis, radiculopathy. Treatment to date includes medications, physical therapy, and acupuncture. A UR decision on 8/28/14 denied the request for L4-5 lumbar laminectomy on the basis that there is no clear clinical evidence of radiculopathy. The requests for inpatient stay, assistant surgeon, pre-operative medical clearance, chest x-ray, EKG, UA, MRSA screen, and LSO brace were denied because they are not applicable given the non-certification of the surgical procedure.

IMR ISSUES, DECISIONS AND RATIONALES

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

L4-5 Posterior Lumbar Laminectomy: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305.

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: The California 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 clear symptoms of left lower extremity radiculopathy but objective findings are less clear. The only positive sign on exam is a positive straight-leg-raise on the left; however, there are no documented areas of motor weakness, sensory disturbance, or reflex abnormalities. There are no available electrodiagnostic studies that would corroborate objective exam and imaging findings. The latest MRI does not show clear-cut nerve root impingement. It is noted in the recent follow-up note that a new MRI is pending. It is not clear that the patient's current condition is clearly limiting her function, although it does appear that a significant trial of conservative therapy has been attempted. The medical necessity of the requested procedure has not been established at this time. Therefore, the request for L4-5 posterior lumbar laminectomy is not medically necessary.

1-Day Inpatient Stay: 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): Low Back Chapter

Decision rationale: The California MTUS does not address this issue. Official Disability Guidelines recommends a 1-day length of stay in the hospital after lumbar laminectomy. The current request for 1 day is warranted, however, it does not apply because the surgical procedure is not medically necessary. Therefore, the request for 1-day inpatient stay is not medically necessary.

Assistant Surgeon: 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 American Academy of Orthopedic Surgeons (AAOS).

Decision rationale: The California MTUS does not address this issue. American Academy of Orthopedic Surgeons Position Statement Reimbursement of the First Assistant at Surgery in

Orthopedics states on the role of the First Assistant: According to the American College of Surgeons: "The first assistant to the surgeon during a surgical operation should be a trained individual capable of participating and actively assisting the surgeon to establish a good working team. The first assistant provides aid in exposure, hemostasis, and other technical functions, which will help the surgeon carry out a safe operation and optimal results for the patient. The role will vary considerably with the surgical operation, specialty area, and type of hospital. "The first assistant's role has traditionally been filled by a variety of individuals from diverse backgrounds. Practice privileges of those acting as first assistant should be based upon verified credentials reviewed and approved by the hospital credentialing committee (consistent with state laws)." In general, the more complex or risky the operation, the more highly trained the first assistant should be. Criteria for evaluating the procedure include:-anticipated blood loss - anticipated anesthesia time -anticipated incidence of intraoperative complications -procedures requiring considerable judgmental or technical skills -anticipated fatigue factors affecting the surgeon and other members of the operating team -procedures requiring more than one operating team. In limb reattachment procedures, the time saved by the use of two operating teams is frequently critical to limb salvage. It should be noted that reduction in costly operating room time by the simultaneous work of two surgical teams could be cost effective. In this case, the use of a surgical assistant would be warranted based upon the complexity of the case. However, the request cannot be certified because the surgical procedure is not medically necessary. Therefore, the request for assistant surgeon is not medically necessary.

History and Physical for Surgery Clearance: 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 (Low Back - Lumbar & Thoracic (Acute & Chronic) Chapter-Pre operative EKG and Lab testing); ACC/AHA 2007 Guidelines on perioperative cardiovascular evaluation and care for non-cardiac surgery

Decision rationale: The California MTUS does not address this issue. Official Disability Guidelines states that pre-operative 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 surgeries 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 non-cardiac 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. In this case, preoperative clearance does

not apply because the surgical procedure is not medically necessary. Therefore, the request for history and physical for surgical clearance is not medically necessary.

Pre-Operative Lab Work- 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 Official Disability Guidelines (ODG): Pulmonary

Decision rationale: The California MTUS does not address this issue. Official Disability Guidelines recommends chest x-ray with acute cardiopulmonary findings by history/physical, or chronic cardiopulmonary disease in the elderly (> 65). Routine chest radiographs are not recommended in asymptomatic patients with unremarkable history and physical. In this case, preoperative chest x-ray does not apply because the surgical procedure is not medically necessary. Therefore, the request for preoperative lab work: chest x-ray is not medically necessary.

Pre-Operative Lab Work- 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 Official Disability Guidelines (Low Back - Lumbar & Thoracic (Acute & Chronic) Chapter-Pre operative EKG and Lab testing); ACC/AHA 2007 Guidelines on perioperative cardiovascular evaluation and care for non-cardiac surgery

Decision rationale: The California MTUS does not address this issue. Official Disability Guidelines 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 surgeries 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 non-cardiac 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. In this case, preoperative EKG does not apply because the surgical procedure is not medically necessary. Therefore, the request for pre-operative lab work- EKG is not medically necessary.

Pre-Operative Lab Work- Urinalysis (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 American Society of Anesthesiologists Practice Advisory for Preanesthesia Evaluation

Decision rationale: The California MTUS and Official Disability Guidelines 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. In this case, preoperative urinalysis does not apply because the surgical procedure is not medically necessary. Therefore, the request for pre-operative lab work- Urinalysis (UA) is not medically necessary.

MRSA (SMethicillin-resistant Staphylococcus aureu) screen: 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 Guidelines for the Control of MRSA:
<http://goapic.org/mrsa.htm>

Decision rationale: The California MTUS and Official Disability Guidelines do not address this issue. Routine culturing of patients or staff for MRSA is not recommended. In the absence of an epidemic, cultures of patients should be done when is medically indicated. During an outbreak, it may be necessary to culture patients or staff without other medical indications for cultures. Cultures of environmental surfaces or objects may be indicated in very unusual epidemiologic circumstances. In the present case, there is no documentation in the available records that indicates the patient had a prior infection with MRSA. In addition, the request for MRSA screening does not apply because it is intended for preoperative use and the surgical procedure is not medically necessary. Therefore, the request for MRSA (Methicillin-resistant Staphylococcus aureus) screen is not medically necessary.

LSO Back Brace: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Low Back Chapter

Decision rationale: The California MTUS states that lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief; however, Official Disability Guidelines states that lumbar supports are not recommended for prevention; as there is strong and consistent evidence that lumbar supports were not effective in preventing neck and back pain. They are recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, and for treatment of nonspecific low back pain as a conservative option. In this case, the lumbar brace does not apply because it is intended for postop use and the surgical procedure is not medically necessary. Therefore, the request for LSO back brace is not medically necessary.