

<b>Case Number:</b>	CM15-0072542		
<b>Date Assigned:</b>	04/22/2015	<b>Date of Injury:</b>	05/05/2011
<b>Decision Date:</b>	06/11/2015	<b>UR Denial Date:</b>	03/17/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/16/2015

### 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 57-year-old female who sustained an industrial injury on 5/05/11, relative to a slip and fall. Past medical history was positive for hypertension and diabetes mellitus. Past surgical history was positive for L5/S1 microdiscectomy on 7/7/14. The 1/14/15 cervical spine MRI impression documented diffuse cervical spondylosis, most pronounced at C5/6, where there was mild grade 1 retrolisthesis of C5 on C6. This was in conjunction with a broad-based disc bulge and uncovertebral and facet arthropathy resulting in moderate to severe left sided neuroforaminal stenosis, mild to moderate right neuroforaminal stenosis, and mild spinal canal stenosis. At C6/7, there was a broad-based disc bulge and uncovertebral and facet arthropathy resulting in mild spinal canal stenosis, mild left sided neuroforaminal stenosis, and mild to moderate right neuroforaminal stenosis. The 2/10/15 treating physician report cited neck pain radiating into both arms with numbness and tingling to the hands. Physical exam documented normal motor function, decreased distal sensation in the bilateral upper extremities, 3+ reflexes, and gait with a cane. The diagnosis was cervical spondylosis with myelopathy. Authorization was requested for anterior cervical discectomy and fusion at C5/6 and C6/7, with 1-2 days inpatient stay and a preoperative appointment to include laboratory evaluations, chest x-ray, and electrocardiogram (EKG) prior to surgery. The 3/17/15 utilization review certified the request for C5/6 and C6/7 anterior cervical discectomy and fusion and 1-2 day inpatient stay. The request for preoperative appointment to include laboratory evaluations, chest x-ray, and EKG prior to surgery was non-certified as routine EKG, chest x-ray, and unspecified labs are no

longer considered medically necessary and the admitting history and physical is the standard responsibility of the treating physician.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Pre-Operative Appointment (lab-work, chest x-ray and EKG): Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

**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; Surgery General Information and Ground Rules, California Official Medical Fee Schedule, 1999 edition, pages 92-93.

**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. Routine pre-operative chest radiographs are not recommended except when acute cardiopulmonary disease is suspected on the basis of history and physical examination. The California Official Medical Fee Schedule states that, under most circumstances, including ordinary referrals, the immediate preoperative visit in the hospital or elsewhere necessary to examine the patient, complete the hospital records, and initiate the treatment program is included in the listed value for the surgical procedure. Although basic lab testing, chest x-ray, and EKG is typically supported for patients of similar age and comorbidities, the medical necessity of the non-specific lab testing requested could not be established. There is no compelling reason to support the medical necessity of a separate certification for the history and physical which is part of the pre-operative process. Therefore the request is not medically necessary.