

Case Number:	CM15-0085535		
Date Assigned:	05/08/2015	Date of Injury:	03/25/2012
Decision Date:	10/02/2015	UR Denial Date:	04/29/2015
Priority:	Standard	Application Received:	05/05/2015

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 37-year-old female who sustained an industrial injury on 3/25/12. Injury occurred when she bent over to take dinner out of the oven and heard a pop in her lower back with onset of pain. Past medical history was positive for NSAID-induced gastritis and body mass index >32. She underwent left L4/5 minimally invasive transforaminal lumbar foraminotomy and discectomy on 4/18/14. Records documented that symptoms were markedly improved for 2 months but then recurred, suggestive of recurrent disc herniation. The 1/12/15 lumbar spine MRI revealed a recurrent left L4/5 lateral disc herniation with disc desiccation resulting in moderate left neuroforaminal narrowing. The 4/9/15 treating physician report cited grade 7/10 low back pain radiating down the left leg with numbness and tingling in the left great toe. Lumbar spine exam documented trace left ankle reflex and 4/5 anterior tibialis, 4-/5 extensor hallucis longus, and 4+/5 gastrocnemius weakness. Sensation was decreased over the left great toe. The injured worker had a recurrent far lateral L4/5 disc herniation with left L5 radiculopathy documented by physical exam (weakness and numbness in the L5 distribution and decreased left Achilles reflex). She had failed conservative treatment including activity modification, medications, and physical therapy. A request for left L4/5 transforaminal epidural steroid injection had been denied. Surgery was recommended. The 4/23/15 treating physician request for left L4/5 minimally invasive foraminotomy, discectomy stated that the injured worker had failed over one year of conservative treatment including medications, physical therapy, and activity modification. Imaging showed a 3 mm left foraminal/far lateral disc protrusion at L4/5 resulting in moderate left neuroforaminal narrowing. Subjective complaints, activity limitations, and

clinical findings were consistent with imaging evidence. Authorization was requested for revision left L4/5 minimally invasive foraminotomy discectomy, assistant surgeon, lumbar back brace, and preoperative clearance to include labs, electrocardiogram, and chest x-ray. The 4/29/15 utilization review non-certified the revision left L4/5 minimally invasive foraminotomy discectomy and associated surgical requests as there was no imaging evidence of nerve root compression, lateral recess stenosis, or lateral disc rupture, and limited relief with the prior surgery to support this procedure.

IMR ISSUES, DECISIONS AND RATIONALES

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

Revision left L4-5 minimally invasive foraminotomy disectomy: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Indications for Surgery, Discectomy/laminectomy.

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 - Lumbar & Thoracic: Discectomy/Laminectomy.

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 in both 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. Guideline criteria have been met. This injured worker presents with low back pain radiating down the left leg with progressive numbness and weakness. Signs, symptoms, and clinical exam findings are consistent with imaging evidence of a recurrent L4/5 disc herniation with plausible L5 nerve root compromise. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. Therefore, this request is medically necessary.

Assistant Surgeon: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation; The Centers for Medicare and Medicaid Services, Physician Fee Schedule.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Centers for Medicare and Medicaid services, Physician Fee Schedule: Assistant Surgeons, <http://www.cms.gov/apps/physician-fee-schedule/overview.aspx>.

Decision rationale: The California MTUS guidelines do not address the appropriateness of assistant surgeons. The Center for Medicare and Medicaid Services (CMS) provide direction relative to the typical medical necessity of assistant surgeons. The Centers for Medicare & Medicaid Services (CMS) has revised the list of surgical procedures, which are eligible for assistant-at-surgery. The procedure codes with a 0 under the assistant surgeon heading imply that an assistant is not necessary; however, procedure codes with a 1 or 2 implies that an assistant is usually necessary. For this requested surgery, CPT code 63030, there is a "2" in the assistant surgeon column. Therefore, based on the stated guideline and the complexity of the procedure, this request is medically necessary.

Lumbar Back Brace: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM). Occupational Medical Practice Guidelines 2nd Edition. Chapter 12 Low Back Disorders. (Revised 2007) page(s) 138-139.

Decision rationale: The California MTUS guidelines state that lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. The revised ACOEM Low Back Disorder guidelines do not recommend the use of lumbar supports for prevention or treatment of lower back pain. However, guidelines state that lumbar supports may be useful for specific treatment of spondylolisthesis, documented instability, or post-operative treatment. The use of a lumbar support in the post-operative period for pain control is reasonable and supported by guidelines. Therefore, this request is medically necessary.

Preoperative clearance to include labs: 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, Lumbar and Thoracic, Preoperative Electrocardiogram.

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; 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. Guideline criteria have not been met. A generic request for non-specific pre-operative lab work is under consideration. Although, pre-operative clearance and basic lab testing would typically be supported for patients undergoing this procedure and general anesthesia, the medical necessity of a non-specific lab request cannot be established. Therefore, this request is not medically necessary.

Electrocardiogram: Overturned

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, Lumbar and Thoracic, Preoperative Electrocardiogram.

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 state that an 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 have been met based on large body habitus, long-term use of non-steroidal anti-inflammatory drugs, and the risk of anesthesia. Therefore, this request is medically necessary.

Chest X-Ray: Overturned

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, Lumbar and Thoracic, Preoperative Testing, general.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACR Appropriateness Criteria® routine admission and preoperative chest radiography. Reston (VA): American College of Radiology (ACR); 2011.6 p.

Decision rationale: The California MTUS guidelines do not provide recommendations for this service. Evidence based medical guidelines state that routine pre-operative chest radiographs are not recommended except when acute cardiopulmonary disease is suspected based on history and physical examination. Guideline criteria have been met based on large body habitus, long-term use of non-steroidal anti-inflammatory drugs, and the risk of anesthesia. Therefore, this request is medically necessary.

