

Case Number:	CM14-0051236		
Date Assigned:	06/23/2014	Date of Injury:	08/25/2010
Decision Date:	08/29/2014	UR Denial Date:	03/10/2014
Priority:	Standard	Application Received:	03/21/2014

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 Physical Medicine & Rehab and is licensed to practice in Illinois. 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:

The injured worker is a 38-year-old female who reported an injury on 08/25/2010. The mechanism of injury was not provided. On 01/15/2014, the injured worker presented with ongoing cervical spine pain with spasm along the neck and back. The injured worker also reported pain radiating along the arms with numbness and weakness into the bilateral hands. Upon examination, there was a 3+ spasm elicited upon palpation of the paracervical muscles and interscapular musculature. There was also tenderness to palpation over the scalene muscles bilaterally with 3+ spasm and tenderness over the cervical spinous process from C3-7. Range of motion was limited in all planes due to pain and muscle guarding. There was a positive Spurling's test bilaterally with radiation of pain into the bilateral hands, and a positive foraminal compression test with radiation of pain into the bilateral hands. Sensory examination of the upper extremities revealed diffuse hyperesthesia, right greater than left; and sensory examination of the lower extremities revealed diffuse left lower extremity hyperesthesia. The diagnoses were cervical spine disc herniation at C3 through C7 with severe central and lateral stenosis, cervical spine disc protrusion at C3-4, 2 mm, severe spinal cord compression with myelomalacia C4-7, partial Brown-Sequard syndrome, bilateral right greater than left, upper and lower extremity myeloradiculopathy, and status post right shoulder rotator cuff repair 10/2011. Prior treatments include home exercise and medication. The provider recommended a pre-op medical clearance and requested the injured worker to undergo anterior cervical discectomy and fusion at C4-7. The Request for Authorization form was dated 02/27/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Pre-op medical clearance: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) chapter low back.

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, Preoperative testing.

Decision rationale: The request for a pre-op medical clearance is not medically necessary. The Official Disability Guidelines state preoperative additional tests are excessively ordered, even for young injured workers with low surgical risk, with little or no interference in preoperative management. Laboratory tests, besides generating high and unnecessary costs, are not considered as screening instruments for diseases. The decision to order preoperative testing should be guided by the injured worker's clinical history, comorbidities, and physical examination findings. Preoperative routine tests are appropriate if injured workers with normal tests have preoperative modified approach. The medical documents lack evidence of a high surgical risk, or physical exam findings that would be indicative of lab preoperative testing. It is unclear when the laboratory monitoring was last performed for the injured worker. As such, the request is not medically necessary.