

Case Number:	CM14-0120193		
Date Assigned:	08/06/2014	Date of Injury:	10/09/2013
Decision Date:	07/08/2015	UR Denial Date:	07/21/2014
Priority:	Standard	Application Received:	07/30/2014

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. 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: California, Indiana, New York
Certification(s)/Specialty: Internal Medicine

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 male, who sustained an industrial injury on October 9, 2013, incurring low back injuries. He was diagnosed with lumbar disc disease, lumbar ligament strain and bilateral lumbar radiculopathy. Treatment included physical therapy, acupuncture, epidural steroid injection, work modifications, pain medications and anti-inflammatory drugs. Currently, the injured worker complained of continued low back pain, numbness, tingling and spasms. The pain was exacerbated with squatting, kneeling, lifting, pushing and pulling. Heat and cold alleviate the pain at times. A request for a posterior spinal fusion and lumbar decompression was suggested. The treatment plan that was requested for authorization included internal medicine clearance.

IMR ISSUES, DECISIONS AND RATIONALES

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

Internal Medicine Clearance: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM second edition, 2004, 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 ACOEM Practice Guidelines, Chapter 7 Independent Medical Examinations and Consultations, page 127 and American Academy of Family Physicians (www.aafp.org).

Decision rationale: Pursuant to the ACOEM and American Family Physician, internal medicine clearance is not medically necessary. An occupational health practitioner may refer to other specialists if the diagnosis is certain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. A consultation is designed to aid in the diagnosis, prognosis and therapeutic management of a patient. The need for a clinical office visit with a healthcare provider is individualized based upon a review of patient concerns, signs and symptoms, clinical stability and reasonable physician judgment. The determination is also based on what medications the patient is taking, since some medications such as opiates for certain antibiotics require close monitoring. Preoperative testing (e.g., chest radiography, electrocardiography, laboratory testing, urinalysis) is often performed before surgical procedures. These investigations 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 preoperative management. Preoperative urinalysis is recommended for patients undergoing invasive urologic procedures and those undergoing implantation of foreign material. Electrolyte and creatinine testing should be performed in patients with underlying chronic disease and those taking medications that predispose them to electrolyte abnormalities or renal failure. Random glucose testing should be performed in patients at high risk of undiagnosed diabetes mellitus. In patients with diagnosed diabetes, A1C testing is recommended only if the result would change perioperative management. A complete blood count is indicated for patients with diseases that increase the risk of anemia or patients in whom significant perioperative blood loss is anticipated. Coagulation studies are reserved for patients with a history of bleeding or medical conditions that predispose them to bleeding, and for those taking anticoagulants. Patients in their usual state of health who are undergoing cataract surgery do not require preoperative testing. In this case, the injured worker's working diagnoses are spondylosis, disc herniation, central stenosis, lateral recess stenosis, and neuroforaminal stenosis L4- L5 and L5- S1 with bilateral lower extremity radiculopathy. The injured worker is scheduled for an L4-S1 anterior posterior fusion. The injured worker is 37 years old with no significant past medical problems. The worker's clinical history, comorbidity conditions and physical examination do not present a high risk for the anticipated surgical procedure. There are no risk factors for heart disease and the injured worker is a non-smoker. There is no past history or co-morbid pulmonary conditions. There is no clinical indication or rationale for an internal medicine clearance based on the available documentation for review. Based on the clinical information in the medical record and the peer-reviewed evidence-based guidelines, internal medicine clearance is not medically necessary.

