

<b>Case Number:</b>	CM14-0026916		
<b>Date Assigned:</b>	06/13/2014	<b>Date of Injury:</b>	12/08/2011
<b>Decision Date:</b>	02/25/2015	<b>UR Denial Date:</b>	01/31/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/03/2014

### 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 (IW) is a 45-year-old man with a date of injury of December 8, 2011. The mechanism of injury occurred as the IW was attempting to turn a pallet jack carrying an 800-pound product. The IW felt a sharp pain in his back and his right ankle. The injured worker's working diagnoses are herniated lumbar disc at L4-L5, and L5-S1 with bilateral radiculopathy, right and left; right ankle sprain/strain, status post prior ORIF with retained hardware, 1990; diabetes; multiple trauma 1990 with fracture of right ankle, left forearm, right and left hand and wrist; psoriasis; and insomnia. Pursuant to the initial orthopedic comprehensive report dated December 19, 2013, the IW reports right ankle pain, low back pain, and anxiety, depression and insomnia due to the pain. Past medical history includes diabetes. There is no documentation whether or no the IW uses insulin. Medications were not documented. Examination of the lumbar spine reveals tightness and spasms in the paraspinal musculature. The treating physician is requesting authorization for discogram at the level of L3-L4, L4-L5, and L5-S1 to isolate the source of pain for a possible posterior lumbar interbody fusion at the level of L4-L5, and L5-S1. The current request is for an internal medicine evaluation for surgical clearance to address the co-morbidity of any existing medical conditions, whether diagnoses or undiagnosed.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Internal Medicine (IM) Pre-Op 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 (ODG); Neck Section, Pre-operative EKG; <http://www.aafp.org/afp/2013/0315/p414.html>

**Decision rationale:** Pursuant to the Official Disability Guidelines and the peer-reviewed evidence-based guidelines (see attached link), internal medicine preoperative clearance is not medically necessary. The decision to order preoperative tests should be guided by the patient's clinical history, comorbidities and physical examination findings. Patients undergoing low-risk surgery do not require an EKG. Patients with signs and symptoms of active cardiovascular disease should be evaluated with appropriate testing, regardless of their preoperative status. Preoperative electrocardiograms are recommended for patients undergoing high-risk surgery and those undergoing intermediate risk surgery have additional risk factors. Patients undergoing low-risk surgery do not require electrocardiography. See the Official Disability Guidelines for details. In this case, the injured worker has a past medical history notable for diabetes mellitus. There are no medications noted in the medical record and, as a result, the documentation does not clarify whether insulin-dependent diabetes for non-insulin-dependent diabetes mellitus. The treating physician requested authorization for a discogram at the level of L3 - L4, L4 - L5, and L5 - S1 isolate the source of pain for a possible posterior lumbar interbody fusion at the level of L4 - L5 and L5 - S1. The procedure is essentially a provocative test, which tries to re-create the pain patients are experiencing (in the progress note dated December 19, 2013). During the discogram, dyes are injected into the spinal disc. X-rays or CT scan is performed and a new treatment plan is developed. This is an outpatient procedure. The documentation goes on to say, an internal medicine evaluation for surgical clearance was prescribed. The injured worker is 45 years old. This evaluation is to address the "comorbidity of any existing medical conditions, whether diagnosed or undiagnosed, as the risk of complications during the procedure need to be minimized. Any existing medical condition needs to be controlled prior to undergoing any procedure." The documentation in the medical record indicates diabetes mellitus was the sole medical problem. There were no medicines documented in the medical record. There was no documentation of any uncontrolled blood sugars in the medical record or any other co-morbid conditions. Consequently, absent uncontrolled comorbid conditions, evidence of uncontrolled diabetes mellitus, preoperative medical clearance for a low risk outpatient procedure is not medically necessary.