

<b>Case Number:</b>	CM15-0005729		
<b>Date Assigned:</b>	02/23/2015	<b>Date of Injury:</b>	04/15/2013
<b>Decision Date:</b>	04/22/2015	<b>UR Denial Date:</b>	12/09/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/12/2015

### 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: Oregon, California  
Certification(s)/Specialty: Neurological 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 47-year-old male who reported an injury on 04/15/2013. The mechanism of injury was not stated. The current diagnoses include lumbar radiculopathy, lumbar disc herniation at L5-S1 and neural foraminal narrowing at L5-S1. The injured worker presented on 12/15/2014 for a follow-up evaluation regarding chronic low back pain. It was noted that the injured worker was utilizing OxyContin 30 mg 4 tablets daily, as well as Percocet 10/325 mg 6 tablets daily. Previous conservative treatment also includes chiropractic therapy, physical therapy, and acupuncture. Upon examination, there was 35 degrees flexion, 10 degrees extension, 15 degrees lateral bending, tenderness to palpation, diminished sensation in the L3-S1 dermatomes on the right, 4+/5 motor weakness on the right, positive Hoffman's test on the right, positive slump test on the right, positive Lasegue's maneuver on the right and positive straight leg raise at 45 degrees on the right. The provider recommended a microlumbar decompressive surgery on the right side at L5-S1 with postoperative chiropractic therapy and preoperative testing. A request for authorization form was then submitted on 12/15/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Pre-Operative Medical Clearance (including a medical consult for History and Physical):**  
Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation National Guideline Clearinghouse, Preoperative Evaluation.

**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 Chapter, Preoperative testing, general.

**Decision rationale:** The Official Disability Guidelines state the decision to order preoperative testing should be guided by the patient's clinical history, comorbidities, and physical examination findings. In this case, there was no documentation of a significant medical history or any comorbidities to support the necessity for preoperative testing. There were no exceptional factors noted. Given the above, the request is not medically appropriate at this time.

**Pre-Operative EKG:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation National Guideline Clearinghouse, Preoperative Evaluation.

**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 Chapter, Preoperative testing, general.

**Decision rationale:** The Official Disability Guidelines state the decision to order preoperative testing should be guided by the patient's clinical history, comorbidities, and physical examination findings. In this case, there was no documentation of a significant medical history or any comorbidities to support the necessity for preoperative testing. There were no exceptional factors noted. Given the above, the request is not medically necessary at this time.

**Pre-Operative Chest X-ray:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation National Guideline Clearinghouse, Preoperative Evaluation.

**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 Chapter, Preoperative testing, general.

**Decision rationale:** The Official Disability Guidelines state the decision to order preoperative testing should be guided by the patient's clinical history, comorbidities, and physical examination findings. In this case, there was no documentation of a significant medical history or any comorbidities to support the necessity for preoperative testing. There were no exceptional factors noted. Given the above, the request is not medically necessary at this time.

**Pre-Operative Labs (phlebotomy therapeutic, autologous blood/component pre-deposit, Chem Panel, CBC, UA, APTT, PT, type and screen): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation National Guideline Clearinghouse, Preoperative Evaluation.

**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 Chapter, Preoperative testing, general.

**Decision rationale:** The Official Disability Guidelines state the decision to order preoperative testing should be guided by the patient's clinical history, comorbidities, and physical examination findings. In this case, there was no documentation of a significant medical history or any comorbidities to support the necessity for preoperative testing. There were no exceptional factors noted. Given the above, the request is not medically necessary at this time.

**Post-Operative Chiropractic Care (12-sessions to the lumbar spine): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58.

**Decision rationale:** The California MTUS Guidelines state manual therapy and manipulation is recommended for chronic pain if caused by a musculoskeletal condition. Treatment for the low back is recommended as a therapeutic trial of 6 visits over 2 weeks. With evidence of objective functional improvement, a total of up to 18 visits over 6 to 8 weeks may be appropriate. The current request for 12 sessions of chiropractic therapy for the lumbar spine would exceed guideline recommendations. Given the above, the request is not medically necessary.