

<b>Case Number:</b>	CM15-0057415		
<b>Date Assigned:</b>	04/17/2015	<b>Date of Injury:</b>	12/11/2009
<b>Decision Date:</b>	05/15/2015	<b>UR Denial Date:</b>	03/13/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/26/2015

### 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:

The injured worker is a 64-year-old female who sustained an industrial injury on 12/11/09. Injury occurred when she tripped over a piece of wood, and fell. Past medical history was positive for diabetes and hypertension. The 10/10/14 lumbar spine MRI impression documented minimal broad-based disc bulge at L4/5 with no central canal or neuroforaminal narrowing. There was thickening of the left ligamentum flavum at L4/5 with a 3 mm synovial cyst causing effacement of the thecal sac. The 11/26/14 electrodiagnostic documented evidence consistent with left L5 radiculopathy. The 2/10/15 treating physician report cited persistent and significant low back and left lower extremity pain. She was ambulating with a cane with significant limp on the left. Physical exam documented lumbar range of motion 20% in all planes, 4+/5 extensor hallucis longus weakness, diminished left calf sensation, and absent bilateral lower extremity reflexes. Straight leg raise as positive on the left at 75%. There was midline spinal tenderness from L1 to the sacrum. The diagnosis was chronic lumbosacral strain, symptom magnifying/malingering, synovial cyst left L4/5, and left L5 radiculopathy. Requests for epidural steroid injection were denied. Surgery was recommended to include lumbar laminectomy at L4 with excision of the left synovial cyst. Associated surgical requests included Pre-operative physical, medical clearance and labs: Chemistry panel, CBC, PT, PTT, UA, Chest x-ray, and EKG. The 3/13/15 utilization review modified the request for pre-operative physical, medical clearance and labs: Chemistry panel, CBC, PT, PTT, UA, chest x-ray, and EKG to include pre-operative physical, CBC, Chemistry panel, chest x-ray, and EKG.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Pre-op physical, medical clearance and labs: Chem panel, CBC, PT, PTT, UA, Chest x-ray, and EKG:** 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 chapter.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Practice advisory for pre-anesthesia evaluation: an updated report by the American Society of Anesthesiologists Task Force on Pre-anesthesia 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. 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. Routine pre-operative chest radiographs are not recommended except when acute cardiopulmonary disease is suspected on the basis of history and physical examination. The 3/13/15 utilization review modified this request to include pre-operative physical, CBC, Chemistry panel, chest x-ray, and EKG. The additional certification of medical clearance, urinalysis and coagulation studies seem reasonable based on patient age, co-morbidities of diabetes and hypertension, plausible use of anti-inflammatory agents, and risks of anesthesia. Therefore, this request is medically necessary.