

Case Number:	CM15-0079828		
Date Assigned:	04/30/2015	Date of Injury:	11/09/2007
Decision Date:	06/01/2015	UR Denial Date:	04/22/2015
Priority:	Standard	Application Received:	04/27/2015

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: New Jersey, Alabama,
 California
 Certification(s)/Specialty: Neurology, Neuromuscular 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 60 year old male, who sustained an industrial injury on 11/09/2007. He reported the vehicle he was climbing into was struck by another vehicle subsequently throwing him off and into another truck injuring his low back and bilateral lower extremities, left greater than right. Diagnoses include post laminectomy syndrome, lumbar facet syndrome, and lumbar stenosis. He is status post lumbar fusion. Treatments to date include activity modification, medication therapy, physical therapy, and epidural steroid injections. Currently, he complained of increasing low back pain. On 2/25/15, the physical examination documented decreased sensation in the right lower extremity from the knee to the foot. The plan of care included laminectomy and fusion L2-3 and revision fusion L3-S1 with associated services pre-operatively and post operatively including diagnostic pre-operative laboratory evaluations, not specified. The records indicated a modification at determination that allowed a Complete Blood Count (CBC), Comprehensive metabolic panel (Comp), and prothrombin time (PT) / partial thromboplastin time (PTT). This request was again for pre-operative laboratory evaluations, not specified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Pre-operative labs: 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), Low Back Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Preoperative lab testing <http://www.odg-twc.com/index.html>.

Decision rationale: According to ODG guidelines, pre-op lab testing: Recommended as indicated below. Preoperative additional tests are excessively ordered, even for young patients with low surgical risk, with little or no interference in perioperative management. Laboratory tests, besides generating high and unnecessary costs, are not good standardized screening instruments for diseases. The decision to order preoperative tests should be guided by the patient's clinical history, co-morbidities, and physical examination findings. Preoperative routine tests are appropriate if patients with abnormal tests will have a preoperative modified approach (i.e., new tests ordered, referral to a specialist or surgery postponement). Testing should generally be done to confirm a clinical impression, and tests should affect the course of treatment. (Feely, 2013) (Sousa, 2013) Criteria for Preoperative lab testing: 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. The above request is not medically necessary.