

Case Number:	CM13-0014247		
Date Assigned:	10/02/2013	Date of Injury:	07/05/2011
Decision Date:	01/17/2014	UR Denial Date:	08/12/2013
Priority:	Standard	Application Received:	08/20/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation, and is licensed to practice in California. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient is a 40-year-old male who reported an injury on 07/05/2011. The patient is diagnosed with low back pain with radiculopathy, thoracic spine pain, cervicgia, bilateral shoulder pain, and bilateral foot and ankle pain. The patient was recently evaluated by [REDACTED] on 10/18/2013. The patient complained of 7-8/10 pain. Physical examination revealed 5/5 muscle strength throughout, normal muscle tone, normal coordination, decreased sensation to light touch in the left S1 dermatome, tenderness to palpation over L3-S1 facet capsules, positive pelvic thrusting on the left, secondary myofascial pain with triggering and ropey fibrotic banding, and positive stork testing on the left. Treatment recommendations included a lumbar fusion with a large disc extrusion at L5-S1 and potential disc replacement surgery at L4-5.

IMR ISSUES, DECISIONS AND RATIONALES

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

Outpatient pre-op lab EKG: 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), Low Back Chapter, Preoperative electrocardiogram (ECG).

Decision rationale: Official Disability Guidelines state preoperative electrocardiogram is recommended for patients undergoing high risk surgery and those undergoing intermediate risk surgery who have additional risk factors. Patients with signs or symptoms of active cardiovascular disease should be evaluated with appropriate testing, regardless of their preoperative status. Low risk surgical procedures include endoscopic procedures, superficial procedures, cataract surgery, breast surgery, and ambulatory surgery. As per the clinical notes submitted, there is no evidence of significant medical history or comorbidities that would require preoperative investigation. The medical necessity for the requested service has not been established. As such, the request is non-certified.

Outpatient pre-op lab lumbar X-rays: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-306. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Preoperative lab testing, Radiography (x-rays).

Decision rationale: Official Disability Guidelines state preoperative lab testing is recommended for specific indications. The decision to order preoperative tests should be guided by the patient's clinical history, comorbidities, and physical examination findings. Radiography is not recommended in the absence of red flags. As per the clinical notes submitted, there is no evidence of a significant medical history of comorbidities that would require preoperative investigation. Additionally, the patient underwent lumbar x-rays on 07/26/2013 and there is no indication as to why this procedure should be repeated. Based on the clinical information received, the request is non-certified.

Outpatient post-op physical therapy 3 times per week for 6 weeks: Upheld

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

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 26.

Decision rationale: The Physician Reviewer's decision rationale: California MTUS Guidelines state postsurgical treatment following a fusion includes 34 visits over 16 weeks. Initial course of therapy means \hat{A} ^{1/2} of the number of visits specified in the general course of therapy for specific surgery in the postsurgical physical medicine treatment recommendations. The current request for postoperative physical therapy 3 times per week for 6 weeks exceeds guideline recommendations. Therefore, the request cannot be determined as medically appropriate. As such, the request is non-certified.