

Case Number:	CM14-0157357		
Date Assigned:	09/30/2014	Date of Injury:	05/02/2012
Decision Date:	11/14/2014	UR Denial Date:	09/16/2014
Priority:	Standard	Application Received:	09/25/2014

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. The expert 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 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/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:

This is a 59-year-old man with a date of injury on 05/02/2012 which involved an unspecified injury to his cervical and lumbar spine for which he has been evaluated and treated numerous times. A 06/22/2014 evaluation reveals subjective complaints of continued cervical and lumbar spine pain aggravated by repetitive movements as well as physical exam findings positive for paravertebral tenderness, bilateral numbness and weakness and positive axial loading compression testing and Spurling's maneuver. His neck and cardiovascular examinations, however, were unremarkable. While he has a medical history that is significant for hypertension, diabetes, dilated cardiomyopathy and hyperlipidemia, which are risk factors for stroke/TIA (transient ischemic attack), his blood pressures were normal and he has blood sugars within appropriate ranges for a known diabetic. Furthermore, he had no subjective complaints of any focal neurological deficits or any symptoms consistent with stroke or TIA. His only complaint on history was his back pain and on review of systems was exertional dyspnea. There is also no evidence of brain, head or neck imaging. Imaging studies and additional testing included were cervical and thoracic spine x-rays/MRIs, EMGs of the bilateral upper extremities, a chest x-ray and an EKG. His primary physician states that he would like for the patient to have a preoperative clearance for spinal surgery. Treatment to date: Patient takes glipizide, Coreg, simvastatin, lisinopril, Lasix, potassium and has taken both ibuprofen and Vicodin for his back pain previously; physical therapy; status post ICD placement. UR Determination: The rationale given by UR was that the accompanying documentation for the carotid duplex request did not contain sufficient information, including subjective complaints, objective findings or medical rationale.

IMR ISSUES, DECISIONS AND RATIONALES

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

Carotid Duplex: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Epub 2014 Jan. 18, Interpretation of Carotid duplex testing, Quirk K1, Bandyk DF2

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: American College of Radiology Indications for an Ultrasound examination of the extracranial carotid and vertebral arteries.

Decision rationale: CA MTUS and ODG do not address this issue. Per the American College of Radiology, evaluation of patients with hemispheric neurologic symptoms, including stroke, transient ischemic attack, and amaurosis fugax [1-4]. 5. Evaluation of patients with a cervical bruit. 6. Evaluation of pulsatile neck masses. 7. Preoperative evaluation of patients scheduled for major cardiovascular surgical procedures. 8. Evaluation of nonhemispheric or unexplained neurologic symptoms. 9. Follow-up of patients with proven carotid disease. 10. Evaluation of postoperative patients following cerebrovascular revascularization, including carotid endarterectomy, stenting, or carotid to subclavian bypass. 11. Intraoperative monitoring of vascular surgery. 12. Evaluation of suspected subclavian steal syndrome [5]. 13. Evaluation for suspected carotid artery dissection [6], arteriovenous fistula or pseudoaneurysm, and 14. Patients with carotid reconstruction after ECMO (extracorporeal membrane oxygenation) bypass. This patient does not meet any of the above criteria for indications for having a carotid ultrasound. He is not exhibiting any stroke or TIA symptoms and does not have a history that is indicative of someone who is at high risk for carotid disease. He does have a history of hypertension, hyperlipidemia and diabetes but he is on appropriate medical therapy, they appear to be relatively well controlled and his cardiomyopathy is unlikely to have any influence on the development of carotid stenosis. Additionally, while his primary provider does state that he is seeking pre-operative cardiac clearance for a possible spinal surgery, a carotid duplex is not considered a standard part of that work-up. Therefore, this request for a Carotid Duplex is not medically necessary.