

Case Number:	CM14-0102044		
Date Assigned:	07/30/2014	Date of Injury:	10/14/1999
Decision Date:	02/10/2015	UR Denial Date:	06/20/2014
Priority:	Standard	Application Received:	07/02/2014

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 Anesthesiology, has a subspecialty in Acupuncture & Pain Medicine 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:

54 year old male injured worker with date of injury 10/14/99 with related back pain. Per progress report dated 6/13/14, the injured worker reported radiation of the pain to the right ankle, right calf, and right foot and thigh. Per physical exam, there was tenderness, decreased thoracic mobility, decreased lumbar mobility, mild kyphosis, bilateral cervical tenderness C3-C7, and L1-S1 bilateral tenderness. Treatment to date has included physical therapy, epidural injection, and medication management. The date of UR decision was 6/20/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lab: Testosterone, Free, LC/MS/MS: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation Page(s): 23. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Preoperative Lab Testing

Decision rationale: Per the ACOEM guidelines: The examining physician should use some judgment about what should or should not be done. Most examinations will need to focus on the presenting complaint. From the items presented, the physician should select what needs to be

done. Besides detecting serious conditions, identifying and categorizing presenting symptoms, and collecting information about the mechanism of injury and apparent work-relatedness, the history establishes rapport between patient and clinician. Asking open-ended questions is a useful way to start the inquiry. The patient's description of the mechanism of injury or illness (so far as is known), his or her presenting symptoms, the duration of symptoms, exacerbating factors, and history of previous episodes will help to define the problem. This description also provides insight into the patient's concerns and expectations, as well as the work, socioeconomic, and psychosocial issues that may affect the patient's response to treatment, functional status, and return to work. The medical history includes the patient's estimate of activity tolerance given his or her symptoms. Perceived activity intolerance contributes to the clinical assessment of the presenting problem, guides treatment and self-care, provides the basis for disability and case management, and establishes a baseline for resuming the activity and evaluating progress. The medical history also should determine whether the present injury or illness is correlated now or in the past with a certain vocational or avocational activity. The documentation submitted for review contains no rationale justifying the necessity of this lab testing. MTUS and ODG guidelines do not address lab testing of this component. Medical practice standard of care makes it reasonable to require documentation of a clearly stated rationale identifying why laboratory tests are needed to support the medical necessity of laboratory tests. The request is not medically necessary.

Lab: Alprazolam (Xanax): Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation Page(s): 23.

Decision rationale: Per the ACOEM guidelines: The examining physician should use some judgment about what should or should not be done. Most examinations will need to focus on the presenting complaint. From the items presented, the physician should select what needs to be done. Besides detecting serious conditions, identifying and categorizing presenting symptoms, and collecting information about the mechanism of injury and apparent work-relatedness, the history establishes rapport between patient and clinician. Asking open-ended questions is a useful way to start the inquiry. The patient's description of the mechanism of injury or illness (so far as is known), his or her presenting symptoms, the duration of symptoms, exacerbating factors, and history of previous episodes will help to define the problem. This description also provides insight into the patient's concerns and expectations, as well as the work, socioeconomic, and psychosocial issues that may affect the patient's response to treatment, functional status, and return to work. The medical history includes the patient's estimate of activity tolerance given his or her symptoms. Perceived activity intolerance contributes to the clinical assessment of the presenting problem, guides treatment and self-care, provides the basis for disability and case management, and establishes a baseline for resuming the activity and evaluating progress. The medical history also should determine whether the present injury or illness is correlated now or in the past with a certain vocational or avocational activity. The documentation submitted for review contains no rationale justifying the necessity of this lab testing. MTUS and ODG

guidelines do not address lab testing of this component. Medical practice standard of care makes it reasonable to require documentation of a clearly stated rationale identifying why laboratory tests are needed to support the medical necessity of laboratory tests. The request is not medically necessary.

Lab: Complete Blood Count (CBC) with Diff/PLT: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation Page(s): 23.

Decision rationale: Per the ACOEM guidelines: The examining physician should use some judgment about what should or should not be done. Most examinations will need to focus on the presenting complaint. From the items presented, the physician should select what needs to be done. Besides detecting serious conditions, identifying and categorizing presenting symptoms, and collecting information about the mechanism of injury and apparent work-relatedness, the history establishes rapport between patient and clinician. Asking open-ended questions is a useful way to start the inquiry. The patient's description of the mechanism of injury or illness (so far as is known), his or her presenting symptoms, the duration of symptoms, exacerbating factors, and history of previous episodes will help to define the problem. This description also provides insight into the patient's concerns and expectations, as well as the work, socioeconomic, and psychosocial issues that may affect the patient's response to treatment, functional status, and return to work. The medical history includes the patient's estimate of activity tolerance given his or her symptoms. Perceived activity intolerance contributes to the clinical assessment of the presenting problem, guides treatment and self-care, provides the basis for disability and case management, and establishes a baseline for resuming the activity and evaluating progress. The medical history also should determine whether the present injury or illness is correlated now or in the past with a certain vocational or avocational activity. Medical practice standard of care makes it reasonable to require documentation of a clearly stated rationale identifying why laboratory tests are needed to support the medical necessity of laboratory tests. The request is not medically necessary.

Lab: Thyroid Stimulating Hormone (TSH): Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation Page(s): 23.

Decision rationale: Per the ACOEM guidelines: The examining physician should use some judgment about what should or should not be done. Most examinations will need to focus on the presenting complaint. From the items presented, the physician should select what needs to be done. Besides detecting serious conditions, identifying and categorizing presenting symptoms,

and collecting information about the mechanism of injury and apparent work-relatedness, the history establishes rapport between patient and clinician. Asking open-ended questions is a useful way to start the inquiry. The patient's description of the mechanism of injury or illness (so far as is known), his or her presenting symptoms, the duration of symptoms, exacerbating factors, and history of previous episodes will help to define the problem. This description also provides insight into the patient's concerns and expectations, as well as the work, socioeconomic, and psychosocial issues that may affect the patient's response to treatment, functional status, and return to work. The medical history includes the patient's estimate of activity tolerance given his or her symptoms. Perceived activity intolerance contributes to the clinical assessment of the presenting problem, guides treatment and self-care, provides the basis for disability and case management, and establishes a baseline for resuming the activity and evaluating progress. The medical history also should determine whether the present injury or illness is correlated now or in the past with a certain vocational or avocational activity. The documentation submitted for review contains no rationale justifying the necessity of this lab testing. MTUS and ODG guidelines do not address lab testing of this component. Medical practice standard of care makes it reasonable to require documentation of a clearly stated rationale identifying why laboratory tests are needed to support the medical necessity of laboratory tests. The request is not medically necessary.

Lab: Acetaminophen: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation Page(s): 23.

Decision rationale: Per the ACOEM guidelines: The examining physician should use some judgment about what should or should not be done. Most examinations will need to focus on the presenting complaint. From the items presented, the physician should select what needs to be done. Besides detecting serious conditions, identifying and categorizing presenting symptoms, and collecting information about the mechanism of injury and apparent work-relatedness, the history establishes rapport between patient and clinician. Asking open-ended questions is a useful way to start the inquiry. The patient's description of the mechanism of injury or illness (so far as is known), his or her presenting symptoms, the duration of symptoms, exacerbating factors, and history of previous episodes will help to define the problem. This description also provides insight into the patient's concerns and expectations, as well as the work, socioeconomic, and psychosocial issues that may affect the patient's response to treatment, functional status, and return to work. The medical history includes the patient's estimate of activity tolerance given his or her symptoms. Perceived activity intolerance contributes to the clinical assessment of the presenting problem, guides treatment and self-care, provides the basis for disability and case management, and establishes a baseline for resuming the activity and evaluating progress. The medical history also should determine whether the present injury or illness is correlated now or in the past with a certain vocational or avocational activity. The documentation submitted for review contains no rationale justifying the necessity of this lab testing. MTUS and ODG guidelines do not address lab testing of this component. Medical practice standard of care makes

it reasonable to require documentation of a clearly stated rationale identifying why laboratory tests are needed to support the medical necessity of laboratory tests. The request is not medically necessary.

Lab: Cyclobenzaprine, serum/plasma: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation Page(s): 23.

Decision rationale: Per the ACOEM guidelines: The examining physician should use some judgment about what should or should not be done. Most examinations will need to focus on the presenting complaint. From the items presented, the physician should select what needs to be done. Besides detecting serious conditions, identifying and categorizing presenting symptoms, and collecting information about the mechanism of injury and apparent work-relatedness, the history establishes rapport between patient and clinician. Asking open-ended questions is a useful way to start the inquiry. The patient's description of the mechanism of injury or illness (so far as is known), his or her presenting symptoms, the duration of symptoms, exacerbating factors, and history of previous episodes will help to define the problem. This description also provides insight into the patient's concerns and expectations, as well as the work, socioeconomic, and psychosocial issues that may affect the patient's response to treatment, functional status, and return to work. The medical history includes the patient's estimate of activity tolerance given his or her symptoms. Perceived activity intolerance contributes to the clinical assessment of the presenting problem, guides treatment and self-care, provides the basis for disability and case management, and establishes a baseline for resuming the activity and evaluating progress. The medical history also should determine whether the present injury or illness is correlated now or in the past with a certain vocational or avocational activity. The documentation submitted for review contains no rationale justifying the necessity of this lab testing. MTUS and ODG guidelines do not address lab testing of this component. Medical practice standard of care makes it reasonable to require documentation of a clearly stated rationale identifying why laboratory tests are needed to support the medical necessity of laboratory tests. The request is not medically necessary.

Lab: EIA 9 w/ GCMS4/fentanyl/meperidine: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation Page(s): 23.

Decision rationale: Per the ACOEM guidelines: The examining physician should use some judgment about what should or should not be done. Most examinations will need to focus on the presenting complaint. From the items presented, the physician should select what needs to be

done. Besides detecting serious conditions, identifying and categorizing presenting symptoms, and collecting information about the mechanism of injury and apparent work-relatedness, the history establishes rapport between patient and clinician. Asking open-ended questions is a useful way to start the inquiry. The patient's description of the mechanism of injury or illness (so far as is known), his or her presenting symptoms, the duration of symptoms, exacerbating factors, and history of previous episodes will help to define the problem. This description also provides insight into the patient's concerns and expectations, as well as the work, socioeconomic, and psychosocial issues that may affect the patient's response to treatment, functional status, and return to work. The medical history includes the patient's estimate of activity tolerance given his or her symptoms. Perceived activity intolerance contributes to the clinical assessment of the presenting problem, guides treatment and self-care, provides the basis for disability and case management, and establishes a baseline for resuming the activity and evaluating progress. The medical history also should determine whether the present injury or illness is correlated now or in the past with a certain vocational or avocational activity. The documentation submitted for review contains no rationale justifying the necessity of this lab testing. MTUS and ODG guidelines do not address lab testing of this component. Medical practice standard of care makes it reasonable to require documentation of a clearly stated rationale identifying why laboratory tests are needed to support the medical necessity of laboratory tests. The request is not medically necessary.

Lab: Chem 19: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation Page(s): 23.

Decision rationale: Per the ACOEM guidelines: The examining physician should use some judgment about what should or should not be done. Most examinations will need to focus on the presenting complaint. From the items presented, the physician should select what needs to be done. Besides detecting serious conditions, identifying and categorizing presenting symptoms, and collecting information about the mechanism of injury and apparent work-relatedness, the history establishes rapport between patient and clinician. Asking open-ended questions is a useful way to start the inquiry. The patient's description of the mechanism of injury or illness (so far as is known), his or her presenting symptoms, the duration of symptoms, exacerbating factors, and history of previous episodes will help to define the problem. This description also provides insight into the patient's concerns and expectations, as well as the work, socioeconomic, and psychosocial issues that may affect the patient's response to treatment, functional status, and return to work. The medical history includes the patient's estimate of activity tolerance given his or her symptoms. Perceived activity intolerance contributes to the clinical assessment of the presenting problem, guides treatment and self-care, provides the basis for disability and case management, and establishes a baseline for resuming the activity and evaluating progress. The medical history also should determine whether the present injury or illness is correlated now or in the past with a certain vocational or avocational activity. The documentation submitted for review contains no rationale justifying the necessity of this lab testing. MTUS and ODG

guidelines do not address lab testing of this component. Medical practice standard of care makes it reasonable to require documentation of a clearly stated rationale identifying why laboratory tests are needed to support the medical necessity of laboratory tests. The request is not medically necessary.

Lab: hydrocodone & metabolite serum: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation Page(s): 23, Chronic Pain Treatment Guidelines Opioids Page(s): 87.

Decision rationale: Per the ACOEM guidelines: The examining physician should use some judgment about what should or should not be done. Most examinations will need to focus on the presenting complaint. From the items presented, the physician should select what needs to be done. Besides detecting serious conditions, identifying and categorizing presenting symptoms, and collecting information about the mechanism of injury and apparent work-relatedness, the history establishes rapport between patient and clinician. Asking open-ended questions is a useful way to start the inquiry. The patient's description of the mechanism of injury or illness (so far as is known), his or her presenting symptoms, the duration of symptoms, exacerbating factors, and history of previous episodes will help to define the problem. This description also provides insight into the patient's concerns and expectations, as well as the work, socioeconomic, and psychosocial issues that may affect the patient's response to treatment, functional status, and return to work. The medical history includes the patient's estimate of activity tolerance given his or her symptoms. Perceived activity intolerance contributes to the clinical assessment of the presenting problem, guides treatment and self-care, provides the basis for disability and case management, and establishes a baseline for resuming the activity and evaluating progress. The medical history also should determine whether the present injury or illness is correlated now or in the past with a certain vocational or avocational activity. The documentation submitted for review contains no rationale justifying the necessity of this lab testing. MTUS and ODG guidelines do not address lab testing of this component. Medical practice standard of care makes it reasonable to require documentation of a clearly stated rationale identifying why laboratory tests are needed to support the medical necessity of laboratory tests. The request is not medically necessary.

Radiofrequency cervical medial branch nerve block right C3, C4, C5, C6 with IV sedation QTY:4: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 300-301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back Chapter

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300-301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Facet Joint Radiofrequency Neurotomy

Decision rationale: Per MTUS ACOEM, "There is good quality medical literature demonstrating that radiofrequency neurotomy of facet joint nerves in the cervical spine provides good temporary relief of pain. Facet neurotomies should be performed only after appropriate investigation involving controlled differential dorsal ramus medial branch diagnostic blocks" but beyond that MTUS is silent on specific requirements for RF ablation in the cervical spine. Per ODG with regard to facet joint radiofrequency neurotomy: "Under study. Conflicting evidence, which is primarily observational, is available as to the efficacy of this procedure and approval of treatment should be made on a case-by-case basis. Studies have not demonstrated improved function." The ODG indicates that criteria for cervical facet joint radiofrequency neurotomy are as follows: 1. Treatment requires a diagnosis of facet joint pain. See Facet joint diagnostic blocks. 2. Approval depends on variables such as evidence of adequate diagnostic blocks, documented improvement in VAS score, and documented improvement in function. 3. No more than two joint levels are to be performed at one time (See Facet joint diagnostic blocks). 4. If different regions require neural blockade, these should be performed at intervals of not sooner than one week, and preferably 2 weeks for most blocks. 5. There should be evidence of a formal plan of rehabilitation in addition to facet joint therapy. 6. While repeat neurotomies may be required, they should not be required at an interval of less than 6 months from the first procedure. Duration of effect after the first neurotomy should be documented for at least 12 weeks at 50% relief. The current literature does not support that the procedure is successful without sustained pain relief (generally of at least 6 months duration). No more than 3 procedures should be performed in a year's period. Per the above noted citation, no more than two joint levels are to be performed at one time. As the request is for four levels, it is not medically necessary. Furthermore, sedation cannot be used for this procedure.