MAXIMUS Federal Services

Case Number:	CM14-0201435		
Date Assigned:	12/11/2014	Date of Injury:	10/09/2014
Decision Date:	02/04/2015	UR Denial Date:	10/31/2014
Priority:	Standard	Application Received:	12/02/2014

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 Preventive Medicine, has a subspecialty in Occupational Medicine and is licensed to practice in Iowa. 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 patient with date of injury of 10/09/2014. Medical records indicate the patient is undergoing treatment for lumbar strain. Subjective complaints include severe back pain with weakness and pain radiating down buttocks and bilateral legs also complains of numbness in vagina. Objective findings include negative straight leg raise bilaterally, weakness in left quadracep, gastroc coleus weakness, 3+ tenderness on palpation of lumbosacral spine and hypersensitivity of bilateral legs to light touch. MRI of lumbar spine dated 10/27/2014 revealed mild disc bulge and a mild right foraminal disc protrusion, marked right facet disease noted at this level which appears to cause mild mass effect on the exiting right L4 nerve root and the traversing right L5 nerve root. Treatment has consisted of epidural injections, physical therapy, Medrol Dosepak, bed rest and Neurontin. The utilization review determination was rendered on 10/31/2014 recommending non-certification of Transforaminal epidural steroid injection L4-L5-S1 with fluoroscopy QTY #1, Pre-operative Complete blood count (CBC), and Pre-operative Electrocardiogram (EKG) and Post-operative Physical Therapy 3/wk for the lumbar spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

Transforaminal epidural steroid injection L4-L5-S1 with fluoroscopy QTY #1: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)- Low back, Criteria for the use of Epidural Steroid Injections

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-315,Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Epidural steroid injections (ESIs), therapeutic.

Decision rationale: MTUS Chronic pain medical treatment guidelines state that epidural steroid injections are "Recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy) . . . Epidural steroid injection can offer short term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program." There was medical documentation provided to conclude that other rehab efforts. MTUS further defines the criteria for epidural steroid injections to include: 1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). 3) Injections should be performed using fluoroscopy (live x-ray) for guidance.4) If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at an interval of at least one to two weeks between injections.5) No more than two nerve root levels should be injected using transforaminal blocks.6) No more than one interlaminar level should be injected at one session.7) In the therapeutic phase, repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year. (Manchikanti, 2003) (CMS, 2004) (Boswell, 2007)8) Current research does not support"series-of-three" injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections.The patient has trialed and failed conservative therapy. The patient is in excruciating pain and has previously gotten pain relief from a lumbar ESI. As such, the request for Transforaminal epidural steroid injection L4-L5-S1 with fluoroscopy QTY #1 is medically necessary.

Pre-operative Complete blood count (CBC): Overturned

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 Other Medical Treatment Guideline or Medical Evidence: Preoperative Testing Before Noncardiac Surgery: Guidelines and Recommendations, Feely, American Family Physician, aafp.org.

Decision rationale: A complete blood count (CBC)--specifically, measurement of hemoglobin and hematocrit values--is often obtained as part of the preoperative assessment. Although evidence suggests that the preoperative hematocrit value may predict postoperative mortality, the prevalence of anemia is relatively low.14 Thus, the question of who to test is important.Multiple professional groups have made recommendations about preoperative CBC, hemoglobin, and hematocrit testing.2, 3, 8. These recommendations are based on low-level evidence or expert

opinion. None of the guidelines recommend indiscriminate preoperative CBC or hemoglobin testing. Instead, the consensus is to recommend testing for select patients based on conditions that would increase the pretest probability of diagnosing anemia (e.g., a chronic inflammatory condition, chronic kidney disease, chronic liver disease, clinical signs or symptoms of anemia) or procedures in which significant blood loss is anticipated. This may necessitate a conversation with the surgeon about the expected blood loss for a given procedure. However, at a minimum, if the surgeon orders a type and cross (as opposed to a type and screen) in preparation for a procedure, it is likely that significant blood loss is anticipated. In this case, baseline hemoglobin and hematocrit measurements can help assess the blood loss and inform the need for transfusion.Medical documentation provided indicates this patient has a history of hypertension and obesity. These diagnoses put the patient at an increased risk for a cardiac event. A baseline complete blood count prior to surgical intervention falls within guideline recommendations. As such, the request for Pre-operative Complete blood count (CBC) is medically necessary.

Pre-operative Electrocardiogram (EKG): Overturned

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 Other Medical Treatment Guideline or Medical Evidence: Preoperative Testing Before Noncardiac Surgery: Guidelines and Recommendations, Feely, American Family Physician, aafp.org.

Decision rationale: Five guidelines address recommendations for preoperative ECG2-4, 7, 8; each is based primarily on low-level evidence and expert opinion. There is consensus among the guidelines that patients with active cardiovascular signs or symptoms should undergo ECG. The most widely accepted guideline in the [redacted] advocates against ECG in patients undergoing low-risk surgery.4 The dilemma arises in how to define low perioperative cardiac risk, and what to do for patients who do not have active cardiovascular symptoms and who are not undergoing low-risk surgery. A recommendation based solely on age is an attractive solution because of its simplicity, but fails to address the question of who is at risk of perioperative cardiac morbidity and mortality.Surgical cardiac risk is considered low if the risk of a perioperative cardiac event is less than 1 percent, intermediate if 1 to 5 percent, and high if greater than 5 percent 4,7 (Table 14). Patients should have preoperative ECG before undergoing a high-risk procedure. Two guidelines recommend using the Revised Cardiac Risk Index (RCRI) to assess the risk of cardiac complications after noncardiac surgery 4, 7 (Table 210). The RCRI consists of five clinical risk factors and one procedural risk factor. The procedural risk factor utilized by [redacted] in the RCRI combines high- and intermediate-risk surgeries, which complicates modern risk stratification. As such, current guidelines primarily utilize the clinical risk factors from the RCRI but not the procedural risk factor. ECG is recommended before intermediate-risk procedures in patients with at least one clinical risk factor identified by the RCRI; those with two or more clinical risk factors are at significantly higher risk of a major cardiac event. ECG is not needed in patients undergoing low-risk procedures (Figure 1).Medical documentation provided indicate that this patient has a diagnosis of hypertension and obesity, these two diagnosis

increase this patient's risk factors for a cardiac event during an invasive procedure. As such, the request for Pre-operative Electrocardiogram (EKG) is medically necessary.

Post-operative Physical Therapy 3/wk for the lumbar spine: 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): 287-315,Chronic Pain Treatment Guidelines Physical Therapy, Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Physical Therapy.

Decision rationale: California MTUS guidelines refer to physical medicine guidelines for physical therapy and recommends as follows: "Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine." Additionally, ACOEM guidelines advise against passive modalities by a therapist unless exercises are to be carried out at home by patient. ODG quantifies its recommendations with 10 visits over 8 weeks for lumbar sprains/strains and 9 visits over 8 weeks for unspecified backache/lumbago. ODG further states that a "six-visit clinical trial" of physical therapy with documented objective and subjective improvements should occur initially before additional sessions are to be warranted. The treating physician has not detailed the number of sessions that are being requested. Guidelines recommend a 6 visit clinical trial and re-evaluation. As such, the request for Post-operative Physical Therapy 3/wk for the lumbar spine is not medically necessary.