

<b>Case Number:</b>	CM15-0162251		
<b>Date Assigned:</b>	09/04/2015	<b>Date of Injury:</b>	11/11/2002
<b>Decision Date:</b>	10/21/2015	<b>UR Denial Date:</b>	08/08/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/18/2015

### 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: Arizona, Michigan

Certification(s)/Specialty: Preventive Medicine, Occupational 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 61 year old male, who sustained an industrial injury on 11-11-2002. Diagnoses include brachial plexus lesions, chronic pain, neurovascular compression syndrome and scalene spasm and dystonia. Treatment to date has included a prior scalene block after which his pain and function were much improved for several weeks. Per the Primary Treating Physician's Progress Report dated 7-24-2015, the injured worker presented for recheck and medications for continuation of upper extremity pain. Physical examination of the upper extremities revealed a dusky bluish discoloration of the right upper extremity and hand as compared to the left with decreased temperature. There were muscle spasms of the cervicobrachial and right scalene areas. Posture was altered due to right shoulder depression and internal rotation of the right shoulder. The plan of care included, and authorization was requested on 8-08-2015 for one right scalene Botox injection and medical clearance.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**One (1) right scalene Botox injection:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder (Acute & Chronic) / Anterior scalene block.

**Decision rationale:** The MTUS did not address the use of scalene blocks, therefore other guidelines were consulted. Per the ODG, it is recommended if response to exercise is protracted. Anterior scalene block has been reported to be efficacious in the relief of acute thoracic outlet symptoms, and as an adjunct to diagnosis. A review of the injured workers medical records reveal a diagnosis of brachial plexus lesion as well as thoracic outlet syndrome and neurovascular compression syndrome, which was corroborated by physical examination findings of a cool dusky bluish discoloration of the right upper extremity, it was noted that he had a favorable response especially as regarding numbness and weakness to a prior diagnostic scalene block. The use of a scalene block appears appropriate in light of his clinical presentation, therefore the request for One (1) right scalene Botox injection is medically necessary.

**One (1) medical clearance: History & Physical: Overturned**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Surgery General Information and Ground Rules, California Official Medical Fee Schedule, 1999 edition, pages 92-93.

**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 - Lumbar & Thoracic (Acute & Chronic) / Preoperative testing, general.

**Decision rationale:** The MTUS / ACOEM did not address the use of preoperative medical clearance therefore alternative guidelines were consulted. Per the ODG, an alternative to routine preoperative testing for the purpose of determining fitness for anesthesia and identifying patients at high risk of postoperative complications may be to conduct a history and physical examination, with selective testing based on the clinician's findings. However, the relative effect on patient and surgical outcomes, as well as resource utilization, of these two approaches is unknown. However, given the nature of the injured workers clinical presentation and diagnosis, the request for a medical clearance appears appropriate, therefore the request for One (1) medical clearance: History & Physical is medically necessary.

**EKG: Overturned**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Institute for Clinical Systems Improvement (ICSI). Preoperative evaluation. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI): 2006 Jul. 33 p.

**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 - Lumbar & Thoracic (Acute & Chronic) / Preoperative electrocardiogram.

**Decision rationale:** The MTUS / ACOEM did not address the use of preoperative electrocardiogram therefore other guidelines were consulted. Per the ODG, "recommended for patients undergoing high-risk surgery and those undergoing intermediate-risk surgery who have additional risk factors. Patients undergoing low-risk surgery do not require electrocardiography. Patients with signs or symptoms of active cardiovascular disease should be evaluated with appropriate testing, regardless of their preoperative status. Preoperative ECGs in patients without known risk factors for coronary disease, regardless of age, may not be necessary. Preoperative and postoperative resting 12-lead ECGs are not indicated in asymptomatic persons undergoing low-risk surgical procedures. Low risk procedures (with reported cardiac risk generally less than 1%) include endoscopic procedures; superficial procedures; cataract surgery; breast surgery; & ambulatory surgery. An ECG within 30 days of surgery is adequate for those with stable disease in whom a preoperative ECG is indicated. (Fleisher, 2008) (Feely, 2013) (Sousa, 2013) Criteria for Preoperative electrocardiogram (ECG): High Risk Surgical Procedures: These are defined as all vascular surgical procedures (with reported cardiac risk often more than 5%, which is the combined incidence of cardiac death and nonfatal myocardial infarction), and they include: Aortic and other major vascular surgery; & Peripheral vascular surgery. Preoperative ECG is recommended for vascular surgical procedures. A review of the injured workers medical records reveal clinical features of vascular thoracic outlet syndrome, In this case, a preoperative EKG appears warranted in light of his clinical presentation, therefore the request for EKG appears medically necessary.

**Labs:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Risk assessment for and strategies to reduce perioperative pulmonary complications for patients undergoing non-cardiothoracic surgery: a guideline from the American College of Physicians. American College of Physicians - Medical Specialty Society. 2006 Apr 18. 6 pages.

**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 - Lumbar & Thoracic (Acute & Chronic) / Preoperative lab testing.

**Decision rationale:** The MTUS / ACOEM did not address the use of preoperative lab testing, therefore other guidelines were consulted. Per the ODG, preoperative lab testing is recommended. 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, comorbidities, 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. However, a review of the injured workers medical records did not reveal any specific lab tests, without this information it is not possible to determine medical necessity, therefore the request for labs is not medically necessary.