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| **Case Number:** | CM15-0163546 | | |
| **Date Assigned:** | 08/31/2015 | **Date of Injury:** | 04/13/2014 |
| **Decision Date:** | 10/08/2015 | **UR Denial Date:** | 08/14/2015 |
| **Priority:** | Standard | **Application Received:** | 08/20/2015 |

## 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: California
Certification(s)/Specialty: Physical Medicine & Rehabilitation

## 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 56 year old female, who sustained an industrial injury on 04-13-2014. She has reported injury to the low back. The diagnoses have included lumbago, chronic right L5- S1 disc herniation with S1 neural impingement, lumbar sprain-strain, and lumbar radiculopathy. Treatment to date has included medications, diagnostics, activity modifications, TENS (transcutaneous electrical nerve stimulation) unit, epidural steroid injection, and physical therapy. Medications have included Tramadol, Norco, Amitriptyline, Flexeril, and Omeprazole. A progress report from the treating physician, dated 07-14-2015, documented an evaluation with the injured worker. Currently, the injured worker complains of severe low back pain with pain radiating down the right leg, this is progressively getting worse, she has numbness and tingling in the lateral border of the right leg and foot, and she has undergone two epidural injections with only temporary relief. Objective findings included diffuse tenderness throughout the lower lumbar area to the right of midline, range of motion demonstrates forward bending at 30 degrees, extension is to neutral, straight leg raising is positive on the right at 45 degrees, and she has an absent ankle jerk on the right with hypesthesia in the S1 distribution. Surgical intervention is recommended with right L5-S1 lumbar decompression. The treatment plan has included the request for cardiac clearance, echo ultrasound, holter monitor, and treadmill stress test.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Cardiac clearance:** Overturned

**Claims Administrator guideline:** Decision based on MTUS General Approaches 2004, Section(s): General Approach to Initial Assessment and Documentation. Decision based on Non-MTUS Citation Official Disability Guidelines - Treatment for Workers' Compensation (ODG-TWC), Online Edition, Low Back - Lumbar & Thoracic (Acute & Chronic).

**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) Chapter, under Preoperative electrocardiogram (ECG).

**Decision rationale:** The patient presents with low back pain radiating to the right lower extremity. The request is for CARDIAC CLEARANCE. Physical examination to the lumbar spine on 07/14/15 revealed diffuse tenderness throughout the lower lumbar area to the right of midline. Range of motion was noted to be decreased. Straight leg raising test was positive on the right at 45 degrees. Patient's treatments have included medication, lumbar ESI's, physical therapy, TENS unit, activity modification, and image studies. Per 05/29/15 progress report, patient's diagnosis include 6mm protrusion L5-S1 with right neural encroachment, lumbar radicuopathy, and lumbar sprain/strain. Patient's medications, per 05/01/15 progress report include Duloxetine, Hydrocodone, Naproxen, Pantoprazole, Cyclobenzaprine, and Ambien. Patient is temporarily totally disabled. ODG-TWC, Low Back - Lumbar & Thoracic (Acute & Chronic) Chapter, under Preoperative electrocardiogram (ECG) state: 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. Intermediate Risk Surgical Procedures: These are defined as procedures with intermediate risk (with reported cardiac risk generally 1-5%), and they include: Intraperitoneal and intrathoracic surgery; Carotid endarterectomy; Head and neck surgery; & Orthopedic surgery, not including endoscopic procedures or ambulatory surgery. Preoperative ECG is recommended for patients with known CHD, peripheral arterial disease, or cerebrovascular disease; Preoperative ECG may be reasonable in patients with at least 1 clinical risk factor: History of ischemic heart disease; History of compensated or prior HF; History of cerebrovascular disease, diabetes mellitus, or renal insufficiency. Low Risk Surgical Procedures:

These are defined as procedures with low risk (with reported cardiac risk generally less than 1%), and they include: Endoscopic procedures; Superficial procedures; Cataract surgery; Breast surgery; & Ambulatory surgery. ECGs are not indicated for low risk procedures. The treater has not specifically addressed this request; no RFA was provided either. The patient suffers from severe low back pain that radiates to the right lower extremity and has been authorized for right L5-S1 lumbar decompression surgery, as per the Utilization Review letter dated 08/14/15. ODG guidelines does support pre-op evaluations to determine what is needed for pre-operative assessment. The request appears to be reasonable and therefore IS medically necessary.

**Echo ultrasound:** Upheld

**Claims Administrator guideline:** Decision based on MTUS General Approaches 2004, Section(s): General Approach to Initial Assessment and Documentation. Decision based on Non-MTUS Citation ODG-TWC, Online Edition, Low Back - Lumbar & Thoracic (Acute & Chronic).

**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) Chapter, under Preoperative electrocardiogram (ECG).

**Decision rationale:** The patient presents with low back pain radiating to the right lower extremity. The request is for ECHO ULTRASOUND. Physical examination to the lumbar spine on 07/14/15 revealed diffuse tenderness throughout the lower lumbar area to the right of midline. Range of motion was noted to be decreased. Straight leg raising test was positive on the right at 45 degrees. Patient's treatments have included medication, lumbar ESI's, physical therapy, TENS unit, activity modification, and image studies. Per 05/29/15 progress report, patient's diagnosis include 6mm protrusion L5-S1 with right neural encroachment, lumbar radicuopathy, and lumbar sprain/strain. Patient's medications, per 05/01/15 progress report include Duloxetine, Hydrocodone, Naproxen, Pantoprazole, Cyclobenzaprine, and Ambien. Patient is temporarily totally disabled. ODG-TWC, Low Back - Lumbar & Thoracic (Acute & Chronic) Chapter, under Preoperative electrocardiogram (ECG) state: '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. Intermediate Risk

Surgical Procedures: These are defined as procedures with intermediate risk (with reported cardiac risk generally 1-5%), and they include: Intraperitoneal and intrathoracic surgery; Carotid endarterectomy; Head and neck surgery; & Orthopedic surgery, not including endoscopic procedures or ambulatory surgery. Preoperative ECG is recommended for patients with known CHD, peripheral arterial disease, or cerebrovascular disease; Preoperative ECG may be reasonable in patients with at least 1 clinical risk factor: History of ischemic heart disease; History of compensated or prior HF; History of cerebrovascular disease, diabetes mellitus, or renal insufficiency. Low Risk Surgical Procedures: These are defined as procedures with low risk (with reported cardiac risk generally less than 1%), and they include: Endoscopic procedures; Superficial procedures; Cataract surgery; Breast surgery; & Ambulatory surgery. ECGs are not indicated for low risk procedures. The treater has not specifically discussed this request; no RFA was provided either. The patient suffers from severe low back pain that radiates to the right lower extremity and has been authorized for right L5-S1 lumbar decompression surgery, as per the Utilization Review letter dated 08/14/15. ODG guidelines recommend pre-operative ECG for patients with known CHD, peripheral arterial disease, or cerebrovascular disease. In this case, the treater has not documented any heart or vascular condition that would necessitate a pre-operative ECG. Therefore, the request IS NOT medically necessary.

**Holter monitor:** Upheld

**Claims Administrator guideline:** Decision based on MTUS General Approaches 2004, Section(s): General Approach to Initial Assessment and Documentation. Decision based on Non-MTUS Citation ODG-TWC, Online Edition, Low Back - Lumbar & Thoracic (Acute & Chronic).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Aetna, www.aetna.com/cpb/medical/data/1_99/0019.html.

**Decision rationale:** The patient presents with low back pain radiating to the right lower extremity. The request is for HOLTER MONITOR. Physical examination to the lumbar spine on 07/14/15 revealed diffuse tenderness throughout the lower lumbar area to the right of midline. Range of motion was noted to be decreased. Straight leg raising test was positive on the right at 45 degrees. Patient's treatments have included medication, lumbar ESI's, physical therapy, TENS unit, activity modification, and image studies. Per 05/29/15 progress report, patient's diagnosis include 6mm protrusion L5-S1 with right neural encroachment, lumbar radicuopathy, and lumbar sprain/strain. Patient's medications, per 05/01/15 progress report include Duloxetine, Hydrocodone, Naproxen, Pantoprazole, Cyclobenzaprine, and Ambien. Patient is temporarily totally disabled. MTUS and ODG Guidelines do not discuss Holter Monitor. Aetna, aetna.com/cpb/medical/data/1_99/0019.html, considers Holter monitoring medically necessary for diagnostic evaluation of members with any of the following symptoms or conditions: As a method to assess treatment effectiveness in individuals with baseline high frequency, reproducible, sustained, symptomatic premature ventricular complexes, supraventicular arrhythmias or ventricular tachycardia; or Autonomic cardiac neuropathy associated with diabetes mellitus; or Idiopathic hypertrophic or dilated cardiomyopathy; orIn individuals with pacemakers to assess paroxysmal symptoms, myopotential inhibition, pacemaker medicated

tachycardia, anti-tachycardia pacing device functioning, rate-responsive physiologic pacing function; or Individuals with pain suggestive of Prinzmetal's angina; or Post myocardial infarction with left ventricular dysfunction; or Symptoms related to rhythm disturbances (e.g., frequent palpitation, syncope, unexplained dizziness, frequent arrhythmias). Aetna considers Holter monitoring experimental and investigational for all other indications because its effectiveness for indications other than the ones listed above has not been established. The treater has not specifically discussed this request; no RFA was provided either. The patient suffers from severe low back pain that radiates to the right lower extremity and has been authorized for right L5-S1 lumbar decompression surgery, as per the Utilization Review letter dated 08/14/15. In this case, the patient does not present with hypertension or any heart condition that would necessitate a Holter monitor. Therefore, the request IS NOT medically necessary.

**Treadmill stress test:** Upheld

**Claims Administrator guideline:** Decision based on MTUS General Approaches 2004, Section(s): General Approach to Initial Assessment and Documentation. Decision based on Non-MTUS Citation ODG-TWC, Online Edition, Low Back - Lumbar & Thoracic (Acute & Chronic).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation US National Library of Medicine, www.nlm.nih.gov/medlineplus/ency/article/003878.htm.

**Decision rationale:** The patient presents with low back pain radiating to the right lower extremity. The request is for TREADMILL STRESS TEST. Physical examination to the lumbar spine on 07/14/15 revealed diffuse tenderness throughout the lower lumbar area to the right of midline. Range of motion was noted to be decreased. Straight leg raising test was positive on the right at 45 degrees. Patient's treatments have included medication, lumbar ESI's, physical therapy, TENS unit, activity modification, and image studies. Per 05/29/15 progress report, patient's diagnosis include 6mm protrusion L5-S1 with right neural encroachment, lumbar radicuopathy, and lumbar sprain/strain. Patient's medications, per 05/01/15 progress report include Duloxetine, Hydrocodone, Naproxen, Pantoprazole, Cyclobenzaprine, and Ambien. Patient is temporarily totally disabled. MTUS and ODG Guidelines do not address Treadmill Stress Test. US National Library of Medicine, www.nlm.nih.gov/medlineplus/ency/article/003878.htm, states that an exercise stress test is used to measure the effect of exercise on your heart. Heartsite.com/html/regular_stress.html, has the following: Patients with coronary artery blockages may have minimal symptoms and an unremarkable or unchanged EKG while at rest. However, symptoms and signs of heart disease may become unmasked by exposing the heart to the stress of exercise. During exercise, healthy coronary arteries dilate (develop a more open channel) than an artery that has a blockage. This unequal dilation causes more blood to be delivered to heart muscle supplied by the normal artery. In contrast, narrowed arteries end up supplying reduced flow to its area of distribution. This reduced flow causes the involved muscle to "starve" during exercise. The "starvation" may produce symptoms (like chest discomfort or inappropriate shortness of breath), and the EKG may produce characteristic abnormalities. Most commonly, a motorized treadmill is used for exercise, while a stationary bicycle is used in some exercise laboratories. A regular stress test is

considered in the following circumstances: Patients with symptoms or signs that are suggestive of coronary artery diseases (CAD). Patients with significant risk factors for CAD. To evaluate exercise tolerance when patients have unexplained fatigue and shortness of breath. To evaluate blood pressure response to exercise in patients with borderline hypertension. To look for exercise-induced serious irregular heartbeats. An exercise stress test is used to measure the effect of exercise on your heart. The treater has not specifically discussed this request; no RFA was provided either. The patient suffers from severe low back pain that radiates to the right lower extremity and has been authorized for right L5-S1 lumbar decompression surgery, as per the Utilization Review letter dated 08/14/15. In this case, the patient does not present with any cardiovascular concerns which would necessitate this request. Furthermore, in the utilization review letter dated 08/14/15, it is stated that per the note of 04/08/15, the patient denies any history of cardiac issues. This request IS NOT medically necessary.