

Case Number:	CM15-0165280		
Date Assigned:	09/02/2015	Date of Injury:	03/26/2013
Decision Date:	10/06/2015	UR Denial Date:	07/28/2015
Priority:	Standard	Application Received:	08/24/2015

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, Indiana, New York
 Certification(s)/Specialty: Internal 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:

This 52 year old female sustained an industrial injury to the back on 3-26-13. Previous treatment included physical therapy, acupuncture, epidural steroid injections and medications. Magnetic resonance imaging lumbar spine (9-11-14) showed L4-5 broad based bugle with protrusion, facet arthropathy and canal stenosis, L5-S1 small central protrusion and facet arthropathy at L2-4. In a PR-2 dated 7-8-15, the injured worker complained of low back pain rated 5 out of 10 on the visual analog scale. The injured worker reported having 90% pain relief that lasted for one week and 4 days following epidural steroid injections to bilateral L4-5 and L5-S1 on 5-5-15. The injured worker stated that the pain had been less since the injection but continued to be severe at times. Physical exam was remarkable for lumbar spine with decreased range of motion and tenderness to palpation over the lumbar spine midline L4-S1, with decreased left L3 motor strength, decreased Achilles reflexes bilaterally and positive bilateral straight leg raise. Current diagnoses included lumbar spine herniated nucleus pulposus, lumbar spine degenerative disc disease, lumbar spine radiculopathy and diabetes mellitus. The treatment plan included lumbar decompression at left L4-5 with associated surgical services, ongoing pain management and orthopedic follow up office visit.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ongoing pain management office visit follow up Qty 1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 89.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain section, Office visits.

Decision rationale: Pursuant to the Official Disability Guidelines, ongoing pain management office visit follow-up #1 is not medically necessary. The need for a clinical office visit with a healthcare provider is individualized based upon a review of patient concerns, signs and symptoms, clinical stability and reasonable physician judgment. The determination is also based on what medications the patient is taking, since some medicines as opiates or certain antibiotics require close monitoring. As patient conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. Determination of necessity for an office visit requires individual case review and reassessment being ever mindful that the best patient outcomes are achieved with eventual patient independence from the health care system through self-care as soon as clinically feasible. In this case, the injured worker's working diagnoses are lumbar spine HNP; lumbar spine DDD; lumbar radiculopathy; and diabetes. Date of injury is March 26, 2013. Request for authorization is July 14, 2015. The treating provider requested and was authorized microlumbar decompression left L4 -L5. The documentation shows the only medication taken by the injured worker is ibuprofen. Both Lyrica and Tizanidine are not being taken. There is no clinical indication or rationale for a pain management provider because the injured worker is only taking over-the-counter nonsteroidal anti-inflammatory drugs. The orthopedist requested a follow-up visit. The orthopedist does not specify whether the follow-up visit his preoperative or postoperative period additionally, the treating provider requested a preoperative chemistry panel. The treating provider did not specify a basic chemistry a panel versus a comprehensive chemistry 12 panel. A basic chemistry panel is clinically indicated. A chemistry 12 panel is not indicated based on the clinical documentation. As noted above, the injured worker is taking ibuprofen. There were no other current medications prescribed by the treating provider that require ongoing pain management. In the postsurgical phase, should additional controlled substances be prescribed, the treating provider may reevaluate the injured worker for pain management consultation. Based on the clinical information the medical record, peer-reviewed evidence-based guidelines and no clinical indication or rationale for an ongoing pain management evaluation, ongoing pain management office visit follow-up #1 is not medically necessary.

Orthopedic office visit follow up Qty 1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 89.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain section, Office visits.

Decision rationale: Pursuant to the Official Disability Guidelines, orthopedic office follow-up visit #1 is not medically necessary. The need for a clinical office visit with a healthcare provider is individualized based upon a review of patient concerns, signs and symptoms, clinical stability and reasonable physician judgment. The determination is also based on what medications the patient is taking, since some medicines as opiates or certain antibiotics require close monitoring. As patient conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. Determination of necessity for an office visit requires individual case review and reassessment being ever mindful that the best patient outcomes are achieved with eventual patient independence from the health care system through self-care as soon as clinically feasible. In this case, the injured worker's working diagnoses are lumbar spine HNP; lumbar spine DDD; lumbar radiculopathy; and diabetes. Date of injury is March 26, 2013. Request for authorization is July 14, 2015. The treating provider requested and was authorized microlumbar decompression left L4- L5. The documentation shows the only medication taken by the injured worker is ibuprofen. Both Lyrica and Tizanidine are not being taken. There is no clinical indication or rationale for a pain management provider because the injured worker is only taking over-the-counter nonsteroidal anti-inflammatory drugs. The orthopedist requested a follow-up visit. The orthopedist does not specify whether the follow-up visit his preoperative or postoperative period additionally, the treating provider requested a preoperative chemistry panel. The treating provider did not specify a basic chemistry a panel versus a comprehensive chemistry 12 panel. A basic chemistry panel is clinically indicated. A chemistry 12 panel is not indicated based on the clinical documentation. As noted above, the treating provider does not specify whether the orthopedic follow-up visit is pre or post surgery. Utilization review modified the request to a pre-surgical visit. Based on clinical information, peer-reviewed evidence-based guidelines and lack of specificity in the request for an orthopedic office follow-up, orthopedic office follow-up visit #1 is not medically necessary.

Pre-op Chemistry panel Qty 1: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.aafp.org/afp/2013/0315/p414.html>.

Decision rationale: Pursuant to the Official Disability Guidelines and American Family Physician, preoperative chemistry panel #1 is not medically necessary. Preoperative testing (e.g., chest radiography, electrocardiography, laboratory testing, urinalysis) is often performed before surgical procedures. These investigations can be helpful to stratify risk, direct anesthetic choices, and guide postoperative management, but often are obtained because of protocol rather than medical necessity. The decision to order preoperative tests should be guided by the patient's clinical history, comorbidities, and physical examination findings. Patients with signs or symptoms of active cardiovascular disease should be evaluated with appropriate testing, regardless of their preoperative status. Electrocardiography is 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. Chest radiography is reasonable for patients at risk of postoperative pulmonary complications if

the results would change perioperative management. Preoperative urinalysis is recommended for patients undergoing invasive urologic procedures and those undergoing implantation of foreign material. Electrolyte and creatinine testing should be performed in patients with underlying chronic disease and those taking medications that predispose them to electrolyte abnormalities or renal failure. Random glucose testing should be performed in patients at high risk of undiagnosed diabetes mellitus. In patients with diagnosed diabetes, A1C testing is recommended only if the result would change perioperative management. A complete blood count is indicated for patients with diseases that increase the risk of anemia or patients in whom significant perioperative blood loss is anticipated. Coagulation studies are reserved for patients with a history of bleeding or medical conditions that predispose them to bleeding, and for those taking anticoagulants. Patients in their usual state of health who are undergoing cataract surgery do not require preoperative testing. In this case, the injured worker's working diagnoses are lumbar spine HNP; lumbar spine DDD; lumbar radiculopathy; and diabetes. Date of injury is March 26, 2013. Request for authorization is July 14, 2015. The treating provider requested and was authorized microlumbar decompression left L4 - L5. The documentation shows the only medication taken by the injured worker is ibuprofen. Both Lyrica and Tizanidine are not being taken. There is no clinical indication or rationale for a pain management provider because the injured worker is only taking over-the-counter nonsteroidal anti-inflammatory drugs. The orthopedist requested a follow-up visit. The orthopedist does not specify whether the follow-up visit is preoperative or postoperative period additionally, the treating provider requested a preoperative chemistry panel. The treating provider did not specify a basic chemistry 7 panel versus a comprehensive chemistry 12 panel. A basic chemistry panel is clinically indicated. A chemistry 12 panel is not indicated based on the clinical documentation. Based on the clinical information and medical record, peer-reviewed evidence-based guidelines and a lack of specificity in ordering a chemistry panel (comprehensive chemistry 12 versus basic chemistry 7), preoperative chemistry panel #1 is not medically necessary.