

Case Number:	CM15-0022444		
Date Assigned:	03/18/2015	Date of Injury:	09/14/2013
Decision Date:	04/20/2015	UR Denial Date:	01/15/2015
Priority:	Standard	Application Received:	02/06/2015

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: Indiana

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:

This 63 year old female sustained an industrial injury to the neck and back via cumulative trauma from 9/14/12 to 9/14/13, with subsequent ongoing neck and back pain. Previous treatment included medications, x-rays, magnetic resonance imaging scans, physical therapy and acupuncture. In an orthopedic evaluation dated 7/29/14, the injured worker complained of neck pain with radiation to bilateral shoulders and low back pain with radiation to bilateral lower extremities. The pain was relieved with rest, medications and physical therapy. The injured worker was not interested in having injections or surgery. Current diagnoses included cervical spine discogenic pain with protrusions at C3-4, C4-5 and C5-6 with radiculopathy, thoracic spine degenerative disc disease and lumbar spine multilevel degenerative disc disease with scoliosis, foraminal narrowing, stenosis and radiculopathy. The physician recommended a pain management evaluation for a possible epidural steroid injection.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective request for autonomic testing: cardiovagal innervation and vasomotor adrenergic innervation DOS: 4/30/14: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.ncbi.nlm.nih.gov/pubmed/23346153>.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Pub Med: Autonomic Function Testing: Clinical Applications <http://www.ncbi.nlm.nih.gov/pubmed/23346153>.

Decision rationale: MTUS and ODG are silent regarding autonomic testing. The above-cited peer-reviewed reference states the following: "Modern autonomic function tests can non-invasively evaluate the severity and distribution of autonomic failure. They have sufficient sensitivity to detect even subclinical dysautonomia. Standard laboratory testing evaluates cardiovagal, sudomotor and adrenergic autonomic functions. Cardiovagal function is typically evaluated by testing heart rate response to deep breathing at a defined rate and to the Valsalva maneuver. Sudomotor function can be evaluated with the quantitative sudomotor axon reflex test and the thermoregulatory sweat test. Adrenergic function is evaluated by the blood pressure and heart rate responses to the Valsalva maneuver and to head-up tilt. Tests are useful in defining the presence of autonomic failure, their natural history, and response to treatment. They can also define patterns of dysautonomia that are useful in helping the clinician diagnose certain autonomic conditions. For example, the tests are useful in the diagnosis of the autonomic neuropathies and distal small fiber neuropathy. The autonomic neuropathies (such as those due to diabetes or amyloidosis) are characterized by severe generalized autonomic failure." There is insufficient documentation in the medical record to show what diagnoses are being considered and how specifically autonomic testing will help in narrowing that down. Therefore, the request for autonomic testing is not medically necessary.

Retrospective request for EKG DOS: 4/30/14: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.ncbi.nlm.nih.gov/pubmed/23346153>.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines; Low Back; ECG.

Decision rationale: MTUS is silent on EKG's, but ODG states the following: "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: Intraoperative 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." There is no documentation that the employee has cardiac risk factors that warrant an EKG, therefore, the request is not medically necessary.

Retrospective request for wellness assessment and reporting DOS: 4/30/14: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation
<http://www.ncbi.nlm.nih.gov/pubmed/23346153>.

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

Decision rationale: MTUS is silent regarding visits to a wellness center for assessment. ODG states, "Recommended as determined to be medically necessary. Evaluation and management (E&M) outpatient visits to the offices of medical doctor(s) play a critical role in the proper diagnosis and return to function of an injured worker, and they should be encouraged. The need for a clinical office visit with a health care provider is individualized based upon a review of the 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 such as opiates, or medicines such as certain antibiotics, require close monitoring. As patient conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. The determination of necessity for an office visit requires individualized case review and assessment, 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." It is unclear from the medical documentation how a wellness assessment will improve the diagnosis and care of the employee. Therefore, the request for a wellness assessment and report is not medically necessary.