MAXIMUS Federal Services

Case Number:	CM15-0052116		
Date Assigned:	03/25/2015	Date of Injury:	01/08/2008
Decision Date:	05/11/2015	UR Denial Date:	03/09/2015
Priority:	Standard	Application Received:	03/19/2015

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: Illinois, California, Texas
Certification(s)/Specialty: Orthopedic Surgery

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 64-year-old male who sustained an industrial injury on 1/8/08. Past surgical history was positive for lumbar microdiscectomy in 2010. Past medical history was positive for diabetic neuropathy and heart disease. Conservative treatment including physical therapy, TENS unit, acupuncture, and epidural injection have provided limited relief of symptoms. Records indicated that medications adequately controlled his pain. The 1/27/15 treating physician report cited on-going grade 6-7/10 non-radicular neck pain, and low back pain radiating down both lower extremities to the feet with numbness, left greater than right. Cervical spine exam documented paraspinal tend, decreased range of motion, 5-/5 bilateral wrist flexor and extensor strength, marked upper extremity hyperreflexia, positive Hoffman's and Slump tests bilaterally, and 3 beats of clonus bilaterally. Lumbar spine documented paraspinal tenderness, limited lumbar flexion/extension, decreased L3-S1 sensation bilaterally, 5-/5 left tibialis anterior and psoas strength, bilateral patellar hyperreflexia, and positive straight leg raise. The diagnosis was chronic back pain status post lumbar surgery, cervical and lumbar facet arthropathy, cervical and lumbar myofascial strain, and lumbar herniated nucleus pulposus and spinal stenosis. Authorization was request for left L4/5 and L5/S1 microlumbar decompression, pre-op medical clearance/medical consult for history and physical, EKG, chest x-ray, and labs (CBC, UA, APTT, PT, type and screen), and going follow-up evaluation with PM&R (physical medicine and rehab) for medication management for the cervical/lumbar spine. The 3/9/15 utilization review certified the request for left L4/5 and L5/S1 microlumbar decompression. The request for pre-op medical clearance/medical consult for history and physical, EKG, chest x-ray, and labs (CBC,

UA, APTT, PT, type and screen) was modified to pre-op medical clearance/medical consult for history and physical, EKG, chest x-ray, labs (CBC and comprehensive metabolic panel). The request for on-going follow-up evaluation with PM&R (physical medicine and rehab) for medical management for the cervical spine frequency/duration not specified was modified to one visit for the cervical spine, noting that lumbar spine surgery had been certified. The request for follow-up evaluation with an orthopedic spine specialist (cervical/lumbar) was non-certified as the injured worker was certified for lumbar spine surgery and there were no cervical spine diagnostics submitted that support further follow-up at this time.

IMR ISSUES, DECISIONS AND RATIONALES

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

Pre-operative medical clearance/medical consultation for history and physical /EKG/Chest X-ray/labs (chem panel, CBC, UA, APTT, PT, type and screen): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Practice advisory for preanesthesia evaluation: an updated report by the American Society of Anesthesiologists Task Force on Preanesthesia Evaluation. Anesthesiology 2012 Mar; 116(3):522-38.

Decision rationale: The California MTUS guidelines do not provide recommendations for this service. Evidence based medical guidelines indicate that a basic pre-operative assessment is required for all patients undergoing diagnostic or therapeutic procedures. Guidelines indicate that most laboratory tests are not necessary for routine procedures unless a specific indication is present. Indications for such testing should be documented and based on medical records, patient interview, physical examination, and type and invasiveness of the planned procedure. EKG may be indicated for patients with known cardiovascular risk factors or for patients with risk factors identified in the course of a pre-anesthesia evaluation. Routine pre-operative chest radiographs are not recommended except when acute cardiopulmonary disease is suspected on the basis of history and physical examination. The 3/9/15 utilization review partially certified this request to include pre-op medical clearance/medical consult for history and physical, EKG, chest x-ray, labs (CBC and comprehensive metabolic panel). There is no compelling reason to support the medical necessity of additional lab testing at this time. Therefore, this request is not medically necessary.

Follow-up evaluation with an orthopedic spine specialist (cervical/lumbar): Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 179-180.

Decision rationale: The California MTUS guidelines state that referral for surgical consultation is indicated for patients who have persistent, severe, and disabling shoulder or arm symptoms, with activity limitation for more than one month or with extreme progression of symptoms, and unresolved radicular symptoms after receiving conservative treatment. Guidelines typically require clear clinical, imaging, and electrophysiologic evidence, consistently indicating the same lesion that has been shown to benefit from surgical repair in both the short- and long- term. Guideline criteria have not been met for surgical consultation relative to the cervical spine. There is no imaging or electrodiagnostic evidence presented that demonstrates a surgical lesion. The request for lumbar microdiscectomy has been certified and further evaluation would not be indicated relative to the lumbar spine. Therefore, this request is not medically necessary.

Ongoing follow-up evaluation with a physical medicine & rehabilitation specialist (medical management), frequency and duration not indicated: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Independent Medical Examinations and Consultations, page(s) 127.

Decision rationale: The California MTUS guidelines do not address the frequency/duration of follow-up visits for medication management. The ACOEM guidelines support referral to a specialist if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. A consultant is usually asked to act in an advisory capacity, but may sometimes take full responsibility for treatment of a patient. This injured worker has been under the care of the PM&R physician for medication management. Follow-up in this regard would be indicated. The 3/9/15 utilization review partially certified with non-specific request for one follow-up visit. There is no specific frequency/duration being requested to establish medical necessity. There is no compelling reason for certification of additional follow-up at this time. Therefore, this request is not medically necessary.