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| Case Number: | CM14-0182976 | | |
| Date Assigned: | 11/07/2014 | Date of Injury: | 05/13/2011 |
| Decision Date: | 12/11/2014 | UR Denial Date: | 10/13/2014 |
| Priority: | Standard | Application Received: | 11/03/2014 |

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. The expert reviewer is Board Certified in Internal Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 is a case of a 65-year old male with a date of injury of 5/13/2011. In a recent visit note from [REDACTED] dated 10/2/2014, the patient comes in for a follow up. It is reported that the patient appears to have approximately 1-2 injections per year. He last had an injection in June 2014 and had more than 50% pain relief. He reports the pain has come back and epidurals do help him to be functional. He takes minimal amount of medications, but is always in pain and has difficulty sleeping, but when he does get injections, it helps him more than 50% for over eight weeks. Pain radiates down his left and right legs. He has difficulty walking. He was recommended spinal surgery but wants to hold off pursuing conservative treatment with epidurals and medications. He has a 5 mm herniation at L5-S1. His review of systems was otherwise negative. On physical examination it is noted that he has decreased sensation in the L5 dermatome bilaterally. He has absent ankle reflexes and positive straight leg raising at 40 degrees in the bilateral lower extremities. He is diagnosed with Lumbar disc disease and lumbar spine radiculopathy. At this point it was recommended to obtain authorization for a lumbar steroid epidural injection at the L5-S1 level. In a supplemental report dated 5/20/2014 by [REDACTED], it reports that the patient had diagnostic autonomic nervous system testing which objectively documented that the patient indeed had heart rate changes due to abnormal sympathetic/parasympathetic activity, which correlates to nocturnal obstructions of the airways. The patient also underwent a polysomnogram respiratory study and it objectively documented that the injured worker had nocturnal obstructions of the airways.

IMR ISSUES, DECISIONS AND RATIONALES

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

Monitored Anesthesia Care: Overturned

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: BlueCross BlueShield of North Carolina; Evidence Based Guideline re: Monitored Anesthesia Care; page 3-4. On-Line version. Last reviewed 1/2014.

Decision rationale: MTUS guidelines do not address monitored anesthesia care. In review of evidence based guidelines, monitored anesthesia care may be appropriate for gastrointestinal endoscopy, bronchoscopy, and interventional pain procedures, when there is documentation by the proceduralist and anesthesiologist that specific risk factors or significant medical conditions are present. Those risk factors or significant medical conditions include any of the following: 1) increased risk for complications due to severe co morbidity (ASA P3* or greater). 2) Morbid Obesity, BMI > 40. 3) Documented sleep apnea. 4) Inability to follow simple commands. 4) Spasticity or movement disorder complicating procedure. 6) History or anticipated intolerance to standard sedatives, such as chronic opioid or benzodiazepine use. 7) Patients with active medical problems related to drug or alcohol abuse. 8) Patients of extreme age, i.e. younger than 18 years or age 70 years or older. 9) Patients who are pregnant. 10) Patients at increased risk for airway obstruction due to anatomic variation; such as history of sleep apnea or stridor, dysmorphic facial features, oral, neck, or jaw, abnormalities. 11) Acutely agitated, uncooperative patients. 12) Prolonged therapeutic gastrointestinal endoscopy procedures requiring deep sedation. In this case, the patient has documented nighttime airway obstruction and would be considered a higher risk during his interventional pain procedure. Therefore based on the information in this case and the evidence based guidelines, the request for Monitored Anesthesia Care is medically necessary.