

Case Number:	CM14-0219314		
Date Assigned:	01/09/2015	Date of Injury:	04/04/2010
Decision Date:	03/12/2015	UR Denial Date:	12/23/2014
Priority:	Standard	Application Received:	12/31/2014

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. 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: Texas, California
 Certification(s)/Specialty: Family Practice

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 67 year old female patient, who sustained an industrial injury on 04/04/2010. The diagnoses include brachial neuritis/radiculitis, pain in joint shoulder, cervicgia and rotator cuff sprain. She sustained the injury due to cumulative trauma. Per the office visit dated 12/04/2014 physical examination revealed the cervical spine- decreased range of motion by 5-10 degrees and pain noted on right side, positive for Spurling's test with radiation to right arm with positive triggers; right shoulder- decreased range of motion with pain, positive Hawkin's, Neer's, O'brien and strength 4-/5. The medications list includes norco. She has undergone right shoulder arthroscopic subacromial decompression, biceps tenotomy, debridement of subscapularis partial tear with open rotator cuff repair on 10/14/2010. She has had cervical MRI which revealed disc bulges from C3 to C7, disc dessication in T1-T6 and herniated nucleus pulposus at C3-4 with severe right neuroforaminal stenosis and moderate canal stenosis more on the right side. She has had physical therapy visits for this injury. On 12/23/2014 Utilization Review non-certified the following; ergonomic chair purchase for work station, physical therapy 3 times weekly for 3 weeks, medical clearance, preoperative labs and a cervical ESI with facet at C3-5. The CAMTUS Guidelines for physical medicine/therapy, chronic pain and also the ODG Guidelines. The injured worker submitted an application for IMR for the requested services.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ergonomic Chair for work station: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Neck chapter Ergonomics Chapter:Knee& Leg (updated 02/27/15) Durable medical equipment (DME)

Decision rationale: Request: Q-1-Ergonomic Chair for work stationCA MTUS and ACOEM do not address this request.Per the cited guidelines, regarding ergonomic interventions, "Under study. There was no good-quality evidence on the effectiveness of ergonomics or modification of risk factors."Per the cited guidelines durable medical equipment is "Recommended generally if there is a medical need and if the device or system meets Medicare's definition of durable medical equipment (DME)." .Medical conditions that result in physical limitations for patients may require patient education and modifications to the "environment for prevention of injury, but environmental modifications are considered not primarily medical in nature."Evidence of a physical limitation that would require an ergonomic chair for thework station is not specified in the records provided. The rationale for the need of an ergonomic chair for work is not specified in the records provided.The medical necessity of Ergonomic Chair for work station is not fully established for this patient at this juncture.

Physical therapy 3x3: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 83,Chronic Pain Treatment Guidelines Physical therapy; Physical Medicine Page(s): 103.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical therapy - Page(s): page 98.

Decision rationale: Request: Q-2-Physical therapy 3x3The cited guidelines recommend up to 9-10 physical therapy visits for this diagnosis.The number of physical therapy sessions completed since the date of injury is not specified in the records provided.There is no evidence of significant progressive functional improvement from the previous physical therapy visits that is documented in the records provided. Previous physical therapy visit notes are not specified in the records provided.Per the cited guidelines,"Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels."A valid rationale as to why remaining rehabilitation cannot be accomplished in the context of an independent exercise program is not specified in the records provided.The medical necessity of physical therapy 3x3 is not established for this patient at this time.

Cervical ESI (epidural steroid injection): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs), Page(s): page 46.

Decision rationale: Request: Q-3-Cervical ESI (epidural steroid injection)The MTUS Chronic Pain Guidelines regarding Epidural Steroid Injections state, "The purpose of ESI is to reduce pain and inflammation, restoring range of motion and thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit.Epidural steroid injection can offer short term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program."Per the cited guideline criteria for ESI are "1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants)."The rationale for requesting epidural and facet injectionssimultaneously is not specified in the records provided. As stated above, epidural steroid injection can offer short term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program.Failure to previous conservative therapy including physical therapy visits and pharmacotherapy is not specified in the records provided. As stated above, ESI alone offers no significant long-term functional benefit.The medical necessity of Cervical ESI (epidural steroid injection) is not fully established for this patient.

Facet injection at C3-C5: 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), Criteria for the use of diagnostic blocks for facet nerve pain

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): Initial care page 174-175. Decision based on Non-MTUS Citation Chapter: Neck & Upper Back (updated 11/18/14) Facet joint injections Facet joint diagnostic blocks Facet joint therapeutic steroid injections

Decision rationale: Request: Q-4-Facet injection at C3-C5Per the cited guidelines "Invasive techniques (e.g., needle acupuncture and injection procedures, such as injection of trigger points, facet joints,2 or corticosteroids, lidocaine, or opioids in the epidural space) have no proven benefit in treating acute neck and upper back symptoms."Per the ODG Facet joint therapeutic steroid injections are Not recommended. While not recommended, criteria for use of therapeutic intra-articular and medial branch blocks, if used anyway: Clinical presentation should be consistent with facet joint pain, signs & symptoms. 1. There should be no evidence of radicular pain, spinal stenosis, or previous fusion. 3. When performing therapeutic blocks, no more than 2 levels may be blocked at any one time .5. There should be evidence of a formal plan of rehabilitation in addition to facet joint injection therapy. 6. No more than one therapeutic intra-articular block is recommended.One of the criteria for medial branch blocks or facet joint injections includes that the pain should be non radicular in nature. In this case patient is having a

positive Spurling's test with radiation to right arm with diagnosis of brachial neuritis. The medical necessity of Facet injection at C3-C5 is not fully established for this patient at this juncture.

Medical Clearance: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACC/AHA 2007 Guidelines

MAXIMUS guideline: Decision based on MTUS ACOEM Page(s): Chapter 7, Independent Medical Examinations and Consultations, page 127. Decision based on Non-MTUS Citation Chapter: Low Back (updated 03/03/15) Preoperative testing, general

Decision rationale: Request: Q-5-Medical Clearance Per the cited guidelines, "The occupational health practitioner may refer to other specialists 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." In addition, per the cited guidelines "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." Routine preoperative tests are defined as those done in the absence of any specific clinical indication or purpose and typically include a panel of blood tests, urine tests, chest radiography, and an electrocardiogram (ECG). These tests are performed to find latent abnormalities, such as anemia or silent heart disease, that could impact how, when, or whether the planned surgical procedure and concomitant anesthesia are performed. It is unclear whether the benefits accrued from responses to true-positive tests outweigh the harms of false-positive preoperative tests and, if there is a net benefit, how this benefit compares to the resource utilization required for testing. An alternative to routine preoperative testing for the purpose of determining fitness for anesthesia and identifying patients at high risk of postoperative complications may be to conduct a history and physical examination, with selective testing based on the clinician's findings. However, the relative effect on patient and surgical outcomes, as well as resource utilization, of these two approaches is unknown. (AHRQ, 2013) The latest AHRQ comparative effectiveness research on the benefits and harms of routine preoperative testing, concludes that, except for cataract surgery, there is insufficient evidence comparing routine and per-protocol testing. (AHRQ, 2014). The rationale for this request is not specified in the records provided. As the procedure epidural or facet joint injection itself is not deemed medically necessary the medical necessity of the pre procedure medical clearance is also not fully established. The medical necessity of medical clearance is not fully established for this patient.

Pre-op UA: Comprehensive Metabolic Panel: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.cigna.com/healthwellness/hw/medical-topics/comprehensive-metabolic-panel-tr6153> and on the Non-MTUS Orthopedic Knowledge Update 9, Fischgrund, Editor: Chapter 9, page 105

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Chapter: Low Back (updated 03/03/15) Preoperative lab testing

Decision rationale: Request: Pre-op UA: Comprehensive Metabolic Panel Per the cited guidelines "Preoperative additional tests are excessively ordered, even for young patients with low surgical risk, with little or no interference in perioperative management. Laboratory tests, besides generating high and unnecessary costs, are not good standardized screening instruments for diseases. The decision to order preoperative tests should be guided by the patient's clinical history, comorbidities, and physical examination findings. Preoperative routine tests are appropriate if patients with abnormal tests will have a preoperative modified approach (i.e., new tests ordered, referral to a specialist or surgery postponement). Testing should generally be done to confirm a clinical impression, and tests should affect the course of treatment. (Feely, 2013) (Sousa, 2013) Criteria for Preoperative lab testing: - 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." The details of the presence of any comorbidities or underlying chronic diseases is not specified in the records provided. As the procedure epidural or facet joint injection it self is not medically necessary the medical necessity of Pre-op UA: Comprehensive Metabolic Panel is also not fully established. The medical necessity of Pre-op UA: Comprehensive Metabolic Panel is not fully established for this patient.

MAC (Minimum Alveolar Concentration): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Wheelless textbook of Orthopedics, Orthopedic Anesthesia

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Neck chapter , Facet joint injections Facet joint diagnostic blocks PubMed TI Injury and liability associated with monitored anesthesia care: a closed claims analysis. AU Bhananker SM, Posner KL, Cheney FW, Caplan RA, Lee LA, Domino KB SO Anesthesiology. 2006;104(2):228.

Decision rationale: Request :Q-7-MAC (Monitored Anesthesia Care)BACKGROUND: To assess the patterns of injury and liability associated with monitored anesthesia care (MAC) compared with general and regional anesthesia, the authors reviewed closed malpractice claims in the American Society of Anesthesiologists Closed Claims Database since 1990. Department of Anesthesiology, University of Washington, Virginia Mason Medical Center, Seattle, WA 98195, USA. sbhanank@u.washington.edu In this case MAC stands for monitored anesthesia care. The details of the presence of any comorbidities or underlying chronic diseases is not specified in the records provided. As the procedure epidural or facet joint injection itself is not medically necessary the medical necessity of MAC is also not fully established. Per the criteria for a facet joint injection, "Opioids should not be given as a sedative during the procedure. The use of IV sedation may be grounds to negate the results of a diagnostic block" It is not specified in the records whether the proposed MAC or monitored anesthesia care would involve the use of any opioids or IV sedation. The medical necessity of MAC (Monitored Anesthesia Care) is not fully established for this patient.