MAXIMUS Federal Services

Case Number:	CM15-0177718		
Date Assigned:	09/18/2015	Date of Injury:	08/19/2007
Decision Date:	12/01/2015	UR Denial Date:	08/18/2015
Priority:	Standard	Application Received:	09/09/2015

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, Arizona
Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 58 year old female, who sustained an industrial injury on August 19, 2007. The injured worker was being treated for lumbar post-laminectomy syndrome, lumbago, and thoracic or lumbosacral neuritis or radiculitis, unspecified. Medical records (July 2, 2015 to July 31, 2015) indicate ongoing neck, left shoulder, low back, and left lower extremity pain. The injured worker has ongoing muscle spasms following an exacerbation of pain one month prior. The medical records (July 31, 2015) show the subjective pain rating shows improvement from 8 out of 10 by 50 % with her medications. Records also indicate the ongoing use of muscle relaxant medication since at least March 2015 (Tizanidine since at least March 2015 to July 2015 and cyclobenzaprine since at least July 2015). The physical exam (July 31, 2015) reveals a normal gait, no tenderness of the lumbar spine or soft tissues bilaterally, and lumbar spine range of motion: left and right lateral flexion of 10 degrees, flexion of 25 degrees, and extension of 10 degrees. There is motor strength of 5 out of 5 of the bilateral lower extremities, except for right great toe extension extensor hallucis longus 4 out of 5. There is decreased sensation of the left leg (L2-S1 (lumbar 2-sacral 1)). An MRI of the lumbar spine was performed on June 29, 2015, which revealed moderate to severe bilateral foraminal stenosis from L3-4 (lumbar 3-4) to L5-S1 (lumbar 5-sacral 1) and postoperative changes posteriorly. Surgeries to date have included a decompressive laminectomy at L3-4 and microdiscectomies at L4-5 and L5-S1. Treatment has included lumbar epidural steroid injection and medications including short-acting pain (Hydrocodone and Acetaminophen), long-acting pain (Tramadol ER), muscle relaxant (Cyclobenzaprine since at least July 2015), proton pump inhibitor (Omeprazole), and non-

steroidal anti-inflammatory (Meloxicam). On August 11, 2015, the requested treatments included Cyclobenzaprine 7.5mg #60, pre-operative surgical clearance, pre-operative blood work, pre-operative electrocardiogram (EKG), and pre-operative chest x-ray.On August 18, 2015, the original utilization review non-certified a request for Cyclobenzaprine 7.5mg #60 and partially approved a request for pre-operative surgical clearance, pre-operative blood work, pre-operative electrocardiogram (EKG), and pre-operative chest x-ray.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cyclobenzaprine 7.5mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Muscle relaxant.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Cyclobenzaprine (Flexeril), Muscle relaxants (for pain).

Decision rationale: According to the CA MTUS, Cyclobenzaprine is a muscle relaxant and muscle relaxants are not recommended for the treatment of chronic pain. From the MTUS Guidelines: "Recommend non-sedating muscle relaxants with caution as a second line option for the short-term relief of acute exacerbations in patients with chronic low back pain. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence." Within the submitted records, there was note of a partial certification 7/21/15 on prior review. While this medication is noted to be helpful, allowing for better ability to participate in activities of daily living, and 50% muscle pain reduction, long-term use is not supported. As such, the request is not medically necessary and weaning should be continued, as previously recommended.

Pre-operative surgical clearance: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Preoperative electrocardiogram (ECG), Criteria for preoperative lab testing.

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

Decision rationale: According to the Official Disability 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 are often 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. Chest radiography is

reasonable for patients at risk for post-operative pulmonary complications if the results would change perioperative management. Electrocardiography is recommended for patients undergoing high-risk surgery and those undergoing intermediate risk surgeries with additional risk factors (including coronary artery disease or heart failure). Preoperative electrolyte panels can be considered in those taking medications that predispose to electrolyte abnormalities or renal dysfunction. Preoperative complete blood count can be considered if there is anticipated significant blood loss from surgery, predisposing to blood loss anemia. The injured worker has had clearance for lumbar surgery and therefore, the request for pre-operative surgical clearance is medically necessary and certified.

Pre-operative blood work: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Preoperative electrocardiogram (ECG), Criteria for preoperative lab testing..

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

Decision rationale: According to the Official Disability 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 are often 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. Chest radiography is reasonable for patients at risk for post-operative pulmonary complications if the results would change perioperative management. Electrocardiography is recommended for patients undergoing high-risk surgery and those undergoing intermediate risk surgeries with additional risk factors (including coronary artery disease or heart failure). Preoperative electrolyte panels can be considered in those taking medications that predispose to electrolyte abnormalities or renal dysfunction. Preoperative complete blood count can be considered if there is anticipated significant blood loss from surgery, predisposing to blood loss anemia. Given the approved surgery, preoperative CBC and Basic Metabolic Panel is appropriate, given the above stated guidelines. As such, this request will be medically necessary for pre-surgical CBC and BMP.

Pre-operative EKG: 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), Preoperative electrocardiogram (ECG), Criteria for preoperative lab testing..

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

Decision rationale: According to the Official Disability 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 are often 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. Chest radiography is reasonable for patients at risk for post-operative pulmonary complications if the results would change perioperative management. Electrocardiography is recommended for patients undergoing high-risk surgery and those undergoing intermediate risk surgeries with additional risk factors (including coronary artery disease or heart failure). Preoperative electrolyte panels can be considered in those taking medications that predispose to electrolyte abnormalities or renal dysfunction. Preoperative complete blood count can be considered if there is anticipated significant blood loss from surgery, predisposing to blood loss anemia. There is no history of coronary disease or heart failure. No history of diabetes mellitus. This request for preoperative EKG does not coincide with guidelines and as such, will be not medically necessary.

Pre-operative chest x-ray: 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), Preoperative electrocardiogram (ECG), Criteria for preoperative lab testing.

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

Decision rationale: According to the Official Disability 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 are often 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. Chest radiography is reasonable for patients at risk for post-operative pulmonary complications if the results would change peri-operative management. Electrocardiography is recommended for patients undergoing high-risk surgery and those undergoing intermediate risk surgeries with additional risk factors (including coronary artery disease or heart failure). Preoperative electrolyte panels can be considered in those taking medications that predispose to electrolyte abnormalities or renal dysfunction. Preoperative complete blood count can be considered if there is anticipated significant blood loss from surgery, predisposing to blood loss anemia. There is no mention of significant pulmonary post-operative risk, or issues that would change peri-operative management to coincide with the guidelines. The request as such, is not medically necessary.