

Case Number:	CM15-0179754		
Date Assigned:	09/21/2015	Date of Injury:	07/31/2014
Decision Date:	11/13/2015	UR Denial Date:	09/03/2015
Priority:	Standard	Application Received:	09/12/2015

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
 Certification(s)/Specialty: Emergency 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:

The injured worker is a 46 year old male, who sustained an industrial-work injury on 7-31-14. He reported initial complaints of neck and low back pain. The injured worker was diagnosed as having lumbar strain with disc protrusion, cervical strain with disc bulging, coccydynia, insomnia, anxiety, depression, and left forearm strain. Treatment to date has included medication, ESI (epidural steroid injection), physical therapy, chiropractic treatment, and work restrictions. Currently, the injured worker complains of neck and low back pain with numbness and tingling to both the upper and lower extremities radiating to the hands and toes. Per the primary physician's progress report (PR-2) on 8-21-15, exam noted restricted lumbar range of motion at the endpoints, equal symmetry to the lower extremity reflexes, hypoesthesia along the anterior aspect of the foot in the L5-S1 dermatomal distribution bilaterally with weakness with great toe dorsiflexion and bit toe plantar flexion bilaterally. Cervical range of motion was limited with tightness and spasm to the trapezius, and reflexes were equal. Current plan of care includes return to chiro-physiotherapy, ESI (epidural steroid injection) and lab testing prior to injection for clearance. The Request for Authorization date was 8-27-15 and requested service to include Lab tests: Complete Blood Count, SMA 7, Prothrombin Time/Partial Thromboplastin Time with INR, Urinalysis, along with Physiotherapy/Chiropractor twice a week for six weeks, and Lumbar Epidural Steroid Injection L4-5, L5-S1. The Utilization Review on 9-3-15 denied the request due to lack of risk factors for testing per the ODG (Official Disability Guidelines), Low Back Chapter, Preoperative testing and prior therapy sessions have already been rendered with no indication of acute clinical symptoms for additional therapy, per CA MTUS (California Medical Treatment Utilization Schedule) chronic Pain Medical Treatment Guidelines. 2009.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lab test Complete Blood Count: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Lumbar & Thoracic/Pre-operative lab testing.

Decision rationale: The request is for lab testing. The Official Disability Guidelines state the following regarding this topic: Recommended as indicated below. Pre-operative 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, co-morbidities, and physical examination findings. Pre-operative routine tests are appropriate if patients with abnormal tests will have a pre-operative 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 Pre-operative lab testing: Pre-operative 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. In this case, lab testing is not indicated. This is secondary to poor documentation of qualifying criteria as listed above. As such, the request is not medically necessary.

Lab test: SMA7: Upheld

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

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

Decision rationale: The request is for lab testing. The Official Disability Guidelines state the following regarding this topic: Recommended as indicated below. 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 anti-coagulants. In this case, lab testing is not indicated. This is secondary to poor documentation of qualifying criteria as listed above. As such, the request is not medically necessary.

Lab test: Prothombin Time/Partial Thromboplastin Time with INR: Upheld

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

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

Decision rationale: The request is for lab testing. The Official Disability Guidelines state the following regarding this topic: Recommended as indicated below. 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 anti-coagulants. In this case, lab testing is not indicated. This is secondary to poor documentation of qualifying criteria as listed above. As such, the request is not medically necessary.

Urinalysis: Upheld

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

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

Decision rationale: The request is for lab testing. The Official Disability Guidelines state the following regarding this topic: Recommended as indicated below. 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 anti-coagulants. In this case, lab testing is not indicated. This is secondary to poor documentation of qualifying criteria as listed above. As such, the request is not medically necessary.

Physiotherapy/Chiropractor twice a week for six weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Manual therapy & manipulation.

Decision rationale: The request is for physical therapy to aid in pain relief. The MTUS guidelines states that manipulation is recommended for chronic pain if caused by musculoskeletal conditions. Manual Therapy is widely used in the treatment of musculoskeletal pain. The intended goal or effect of Manual Medicine is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. Manipulation is manual therapy that moves a joint beyond the physiologic range-of-motion but not beyond the anatomic range-of-motion. It is indicated for low back pain but not ankle and foot conditions, carpal tunnel syndrome, forearm/wrist/hand pain, or knee pain. The use of active treatment modalities instead of passive treatments is associated with substantially better

clinical outcomes. (Fritz, 2007) Active treatments also allow for fading of treatment frequency along with active self-directed home PT, so that less visits would be required in uncomplicated cases. The guidelines state the following: Low back: Recommended as an option. Therapeutic care trial of 6 visits over weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks. Elective/maintenance care not medically necessary. Recurrences / flare-ups need to reevaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months. Ankle & Foot: Not recommended. Carpal tunnel syndrome: Not recommended. Forearm, Wrist, & Hand: Not recommended. Knee: Not recommended. In this case, the patient does not qualify for physical therapy as indicated above and would benefit most from at home active therapy. As such, the request is not medically necessary.

Lumbar Epidural Steroid Injection L4-5, L5-S1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Epidural steroid injections (ESIs).

Decision rationale: The request is for an epidural steroid injection to aid in pain relief. There are certain qualifying criteria regarding the use of this treatment modality. The MTUS guidelines state the following on this topic: Criteria for the use of Epidural steroid injections: Note: 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. 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). 3) Injections should be performed using fluoroscopy (live x-ray) for guidance. 4) If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at an interval of at least one to two weeks between injections. 5) No more than two nerve root levels should be injected using transforaminal blocks. 6) No more than one interlaminar level should be injected at one session. 7) In the therapeutic phase, repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year. (Manchikanti, 2003) (CMS, 2004) (Boswell, 2007) 8) Current research does not support a series-of-three injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections. In this case, the patient does not meet the criteria set above. This is secondary to inadequate documentation of pain and functional improvement of at least 50% relief after the first block associated with a reduction of medication use for 6-8 weeks. As such, the request is not medically necessary.