

Case Number:	CM15-0092546		
Date Assigned:	05/18/2015	Date of Injury:	08/16/2001
Decision Date:	06/18/2015	UR Denial Date:	05/09/2015
Priority:	Standard	Application Received:	05/13/2015

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, Indiana, New York
 Certification(s)/Specialty: Internal 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 62-year-old male, who sustained an industrial injury on 8/16/2001. He reported cumulative lifting trauma events that injured the low back, right shoulder and right upper extremity. Diagnoses include status post 360-degree arthrodesis instrumentation, lumbar spine with status post hardware removal, multilevel lumbar disc herniation, cervical sprain/strain, right shoulder sprain/strain, right groin sprain/strain, rule out internal derangement bilateral knees, and failed low back syndrome. Treatments to date include medication therapy and physical therapy. There was a failed morphine intrathecal pump trial 12/2014. Currently, he complained of severe lumbar spine pain, improved with aquatherapy. He complained of worsening neck pain with radiation into the upper back and numbness and tingling in the upper extremity. On 4/9/15, the physical examination documented painful restricted range of motion and positive straight leg raise test. There was decreased sensation to lower extremities. The MRI dated 1/12/15 revealed cervical disc protrusion. The plan of care included cervical epidural steroid injection at C3-4 with epidurogram and pre-operative laboratory evaluations including CBC, PT, PTT, INR, Chem-7, SMA-7 and a urinalysis.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 cervical epidural steroid injection at C3-4 with epidurogram: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of Epidural steroid injections.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injection Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck section, Epidural steroid injection.

Decision rationale: Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, one cervical epidural steroid injection at C3 - C4 with epidurogram is not medically necessary. Epidural steroid injections are recommended as an option for treatment of radicular pain. The criteria are enumerated in the Official Disability Guidelines. The criteria include, but are not limited to, radiculopathy must be documented by physical examination and corroborated by imaging studies and or electro diagnostic testing; initially unresponsive to conservative treatment (exercises, physical methods, non-steroidal anti-inflammatory and muscle relaxants); 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 6 to 8 weeks. Repeat injections should be based on continued objective documented pain relief, decreased need for pain medications and functional response. See the guidelines for details. In this case, the injured worker's working diagnoses are status post 360 arthrodesis instrumentation, lumbar spine, status post hardware removal; cervical spine sprain/strain; herniated disc C3 - C4; right shoulder sprain/strain; bilateral knee sprain/strain; failed low back syndrome; status post intrathecal morphine block with good relief; symptoms of bruxism. The treating provider requested a cervical epidural steroid injection. Epidural steroid injections are indicated when the injured worker is unresponsive to conservative treatment (physical therapy). The treating provider requested an additional 18 sessions of aquatic therapy at the same time as the request for the cervical epidural steroid injection. The request for a cervical epidural steroid injection is premature until aquatic therapy is complete with a reevaluation indicating objective functional improvement or non-improvement. Consequently, absent clinical documentation with a clinical indication and rationale for an epidural steroid injection while the injured worker is presently engaged in aquatic therapy and the treating provider requested an additional 18 aquatics therapy sessions, one cervical epidural steroid injection at C3 - C4 with epidurogram is not medically necessary.

1 pre op labs to include CBC, PT, PTT, INR, Chem-7, SMA-7 and 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 (ODG), Low back, Lumbar & Thoracic (Acute & Chronic) - Preoperative lab testing.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.aafp.org/afp/2013/0315/p414.html>.

Decision rationale: Pursuant to the American Family Physician, preoperative labs including CBC, PT, PTT, INR, Chem-7, SMA-7 and urinalysis are not medically necessary. Preoperative testing (e.g., chest radiography, electrocardiography, laboratory testing, and 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. Electrocardiography is recommended for patients undergoing high-risk surgery and that undergoing intermediate-risk surgery who have additional risk factors. Patients undergoing low-risk surgery do not require electrocardiography. Chest radiography is reasonable for patients at risk of postoperative pulmonary complications if the results would change perioperative management. 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. Patients in their usual state of health who are undergoing cataract surgery do not require preoperative testing. In this case, the injured worker's working diagnoses are status post 360 arthrodesis instrumentation, lumbar spine, status post hardware removal; cervical spine sprain/strain; herniated disc C3 - C4; right shoulder sprain/strain; bilateral knee sprain/strain; failed low back syndrome; status post intrathecal morphine block with good relief; symptoms of bruxism. The preoperative labs were requested prior to the cervical epidural steroid injection. The treating provider requested a cervical epidural steroid injection. Epidural steroid injections are indicated when the injured worker is unresponsive to conservative treatment (physical therapy). The treating provider requested an additional 18 sessions of aquatic therapy at the same time as the request for the cervical epidural steroid injection. The request for a cervical epidural steroid injection is premature until aquatic therapy is complete with a reevaluation indicating objective functional improvement or non-improvement. Absent clinical documentation with a clinical indication and rationale for an epidural steroid injection while the injured worker is presently engaged in aquatic therapy and the treating provider requested an additional 18 aquatics therapy sessions, one cervical epidural steroid injection at C3 - C4 with epidurogram is not medically necessary. The cervical epidural steroid injection at C3 - C4 with epidurogram is not medically necessary and, consequently, preoperative labs including CBC, PT, PTT, INR, Chem-7, SMA-7 and urinalysis are not medically necessary.

1 drug screening: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Urine drug screening Page(s): 43. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain section, Urine drug testing.

Decision rationale: Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, urine drug testing is not medically necessary. Urine drug testing is recommended as a tool to monitor compliance with prescribed substances, identify use of undisclosed substances, and uncover diversion of prescribed substances. This test should be used in conjunction with other clinical information when decisions are to be made to continue, adjust or discontinue treatment. The frequency of urine drug testing is determined by whether the injured worker is a low risk, intermediate or high risk for drug misuse or abuse. Patients at low risk of addiction/aberrant behavior should be tested within six months of initiation of therapy and on a yearly basis thereafter. For patients at low risk of addiction/aberrant drug-related behavior, there is no reason to perform confirmatory testing unless the test inappropriate or there are unexpected results. If required, confirmatory testing should be the questioned drugs only. In this case, the injured worker's working diagnoses are status post 360 arthrodesis instrumentation, lumbar spine, status post hardware removal; cervical spine sprain/strain; herniated disc C3 - C4; right shoulder sprain/strain; bilateral knee sprain/strain; failed low back syndrome; status post intrathecal morphine block with good relief; symptoms of bruxism. The documentation shows the injured worker at a urine drug screen performed on August 7, 2014 that was consistent. The injured worker had a repeat urine drug toxicology screen on April 9, 2015 that was consistent. The injured worker's current medications were Ultram, Norco, alprazolam, and Lyrica. There is no risk assessment in the medical record indicating whether the injured worker is a low-risk, intermediate or high risk for drug misuse or abuse. There is no documentation indicating aberrant drug-related behavior, drug misuse or abuse. Consequently, absent clinical documentation with a clinical indication/rationale, aberrant drug-related behavior, drug misuse or abuse and a risk assessment, urine drug testing is not medically necessary.