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| Case Number: | CM13-0048738 | | |
| Date Assigned: | 12/27/2013 | Date of Injury: | 01/20/2010 |
| Decision Date: | 02/28/2015 | UR Denial Date: | 10/18/2013 |
| Priority: | Standard | Application Received: | 11/06/2013 |

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:

This 45 year old male reportedly sustained a work related injury on January 20, 2010 due to a fall off a ladder. The fall resulted in injury to the neck, back, right shoulder, left wrist and right knee. Diagnoses include cervicalgia, lumbago, left thumb De Quervain's syndrome and dorsal compartment release with ganglion cyst excision and right shoulder, right knee, left elbow and wrist sprain/strain. Magnetic resonance imaging (MRI) in June 2013 revealed normal cervical and thoracic findings and desiccation, protrusion and bulge at L4-L5 and ganglionic cyst next to radial styloid. Treatments include physical therapy, medications, surgery of back, shoulder and knee, Transcutaneous Electrical Nerve Stimulation (TENS), acupuncture and injections. Neurology consultation dated September 26, 2013 provides the injured worker complains of pain consisting of spinal radiating to legs, occipital, right shoulder and arm radiating to hands. He rates it 5-7/10 with medication and 7-8/10 without medication with 10/10 at its worst. Physical exam reveals lumbar tenderness and decreased range of motion (ROM) in neck and low back. Muscle strength is normal. The injured worker is on total temporary disability (TTD). On October 18, 2013 utilization review denied a request received October 11, 2013 for diagnostic interpretation of lumbar spine X-rays, greater than 4 views pre-op clearance to include (labs, chest X-ray and electrocardiogram (EKG)) and bilateral L3 L4 medial branch block with inoperative C- arm fluoroscopy. Medical Treatment Utilization Schedule (MTUS) American College of Occupational and Environmental Medicine (ACOEM) and Official Disability Guidelines (ODG) were utilized in the determination. Application for independent medical review (IMR) is dated November 5, 2013.

IMR ISSUES, DECISIONS AND RATIONALES

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

DIAGNOSTIC INTERPRETATION OF LUMBAR SPINE X-RAYS, GREATER THAN 4 VIEWS: 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 Low back, radiographs

Decision rationale: Pursuant to the Official Disability Guidelines, diagnostic interpretation of lumbar spine x-rays, greater than four views is not medically necessary. Routine x-rays are not recommended the absence of red flags. Lumbar spine radiography should not be recommended in patients with low back pain in the absence of red flags for serious spinal pathology, even if pain has persisted for at least six weeks. Routine imaging for low back pain is not beneficial and may even be harmful, according to new guidelines from the American College of Physicians. Imaging is indicated only if patients have severe progressive neurologic impairments or signs or symptoms indicating a serious or specific underlying condition, or if they are candidates for invasive interventions. In this case, the injured worker's working diagnoses are spinal stenosis lumbar; the generation of lumbar or lumbosacral intervertebral disc; and thoracic or lumbosacral neuritis or radiculitis. The medical record does not contain documentation about a diagnostic interpretation of lumbar spine x-rays. Consequently, absent clinical documentation to support performing a lumbar spine x-ray, a diagnostic interpretation of lumbar spine x-rays, greater than four views is not medically necessary.

PRE-OP CLEARANCE TO INCLUDE (LABS, CHEST X-RAY, AND 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), Low Back

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

Decision rationale: Pursuant to the Official Disability Guidelines and the American Family Physician, preoperative clearance to include laboratories, chest x-ray and electrocardiogram is not medically necessary. A history and physical examination, focusing on risk factors for cardiac, pulmonary and infectious complications, and a determination of the patient's functional capacity, are essential to any preoperative evaluation. Routine laboratory tests are really helpful except to monitor known disease states. Patients with good functional capacity did not require preoperative cardiac stress testing in most surgical cases. Preoperative EKGs are recommended for patients undergoing high-risk surgery and those undergoing intermediate risk surgery who

have additional risk factors. Patients undergoing low-risk surgery do not require electrocardiography. In this case, the injured worker's working diagnoses are spinal stenosis lumbar; the generation of lumbar or lumbosacral intervertebral disc; and thoracic or lumbosacral neuritis or radiculitis. The medical record does not contain documentation about a preoperative clearance. There were no risk factors discussed in the medical record. Additionally, the record indicates the injured worker requires back, shoulder and knee surgery. There is no discussion in the medical record regarding laboratory tests, EKGs or chest x-rays or what type of surgery the injured worker was scheduled to have. Consequently, absent clinical documentation to support a preoperative clearance that includes laboratories, chest x-rays and electrocardiograms, a preoperative clearance to include laboratories, chest x-ray electrocardiogram is not medically necessary.

BILATERAL L3-L4 MEDIAL BRANCH BLOCK W/ INTRAOPERATIVE C-ARM FLUOROSCOPY: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308-310.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 181, Table 8-8.

Decision rationale: Pursuant to the ACOEM and the Official Disability Guidelines, left L3 ? L4 medial branch block is not medically necessary. The ACOEM does not recommend facet injections of steroids or diagnostic blocks. (Table 8 ? 8). The criteria for use of diagnostic blocks for facet-mediated pain include, but are not limited to, patients with lumbar pain that is non-radicular and that no more than two levels bilaterally; documentation of failure of conservative treatment (home exercises, PT, nonsteroidal anti-inflammatory drugs) prior to procedure at least 4 to 6 weeks; etc. In this case, the injured worker's working diagnoses are spinal stenosis lumbar; the generation of lumbar or lumbosacral intervertebral disc; and thoracic or lumbosacral rightists or radiculitis. MRI of the lumbar spine dated June 28, 2013 shows L4-L5 disc desiccation and protrusion with the posterior annulus high-intensity zone and bilateral facet arthropathy. There is broad-based disc bulge at this level, which result in bilateral lateral recess stenosis, left greater than right. There is some mild loss of lordosis. The remainder of the levels are unremarkable. The injured worker complains of pain extending across the entire spine from the cervical region all the way down to the sacral region. The relevant diagnosis is thoracic or lumbosacral neuritis or radiculitis. The injured worker had subjective radicular symptoms, however, there were no objective findings on physical examination. It was no EMG nerve conduction velocity study performed to rule out radiculopathy. The criteria for a diagnostic block for facet mediated pain includes non-radicular lumbar pain and a failure of conservative treatment that includes home exercises and physical therapy and nonsteroidal anti-inflammatory drugs for at least 4 to 6 weeks. There were no physical therapy notes indicating objective functional improvement or non-improvement. Additionally, the ACOEM does not recommend facet injections of steroids or diagnostic blocks (table 8 ? 8). Consequently, absent clinical recommendations according to the guidelines for the clinical radicular symptoms, left L3 ? L4 medial branch block is not medically necessary.