MAXIMUS Federal Services

Case Number:	CM13-0030809		
Date Assigned:	04/25/2014	Date of Injury:	08/19/2003
Decision Date:	06/10/2014	UR Denial Date:	08/30/2013
Priority:	Standard	Application Received:	09/30/2013

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Interventional Spine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient is a 48 YO female with date of injury of 08/19/2013. The listed diagnoses per [redacted] dated 08/29/2013 are complex regional pain syndrome, right upper extremity, complex regional pain syndrome, left upper extremity, insomnia secondary to chronic pain, nausea/vomiting secondary to Tramadol, left scalenectomy. And right thoracic outlet syndrome. According to the report, she presently complains of low back pain. The patient also complains of neck pain that radiates to bilateral upper extremities to the level of shoulder and elbow. The patient also complains of bilateral upper extremity pain. The patient's pain level is unchanged. Insomnia worsens muscle spasm. The patient was noted to be oriented and alert/appropriate. The patient was observed to be in moderate distress. Motor and sensory examination revealed no change. There was allodynia noted in the right upper extremity. The utilization review denied the request on 08/30/2013.

IMR ISSUES, DECISIONS AND RATIONALES

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

ELECTROCARDIOGRAM (EKG): Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation website E-Medicine.Com, Perioperative Management Of The Surgery Patient.

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

Decision rationale: This patient presents with chronic low back, neck, and bilateral upper extremity pain. The treater is requesting an electrocardiogram (EKG). While the guidelines for necessity of EKG for angioplasty is not found, the Official Disability Guidelines (ODG) does support EKG as a pre-operative measure in certain patients undergoing surgery. EKG prior to an angioplasty appear medical reasonable and recommendation is for authorization. The request is medically necessary and appropriate.

CHEST X-RAY: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Harrison's Principles Of Internal Medicine, Edited By Dennis Kasper, M.D., Et Al. 16th Edition, 2005, pages 38-43.

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 Section.

Decision rationale: This patient presents with chronic low back, neck, and bilateral upper extremity pain. The treater is requesting a chest x-ray. The Official Disability Guidelines (ODG) on pre-operative testing states, "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 review of records shows that the patient's last chest x-ray was from 2006. In this case, the patient will undergo a surgical procedure and preoperative chest x-ray is warranted as medically necessary.

PHYSICAL THERAPY: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines PHYSICAL MEDICINE Page(s): 98-99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Section Page(s): 98-99.

Decision rationale: This patient presents with chronic low back, neck, and bilateral upper extremity pain. The California MTUS Guidelines state that Passive therapy can provide short term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. This form of therapy may require supervision from a therapist or medical provider

such as verbal, visual and/or tactile instruction(s). The requested physical therapy is for an unknown quantity and duration. Without understanding the rationale behind the request, duration and frequency of the request, the request cannot be considered. Therefore the requested physical therapy is not medically necessary.