

Case Number:	CM13-0046663		
Date Assigned:	12/27/2013	Date of Injury:	01/18/2011
Decision Date:	04/29/2014	UR Denial Date:	09/24/2013
Priority:	Standard	Application Received:	11/01/2013

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 Emergency Medicine, and is licensed to practice in New York. 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 51-year-old female who was injured on January 18, 2011. The patient continued to experience continuous pain in the neck radiating to the right upper extremity, frequent low back pain, and intermittent right shoulder pain. There were no motor or sensory deficits documented on physical examination. MRI of the lumbar spine was done on March 25, 2011 and showed small disc bulge at L3-4 and disc bulge at L4-5 and L5-S1 with moderate to severe canal stenosis. Diagnoses included cervical disc disease, right shoulder rotator cuff repair, and lumbar spine disease with right radiculitis. Treatment included acupuncture, physical therapy, lumbar brace, and medications. Requests for authorization for follow up evaluation at 4-6 weeks, MRI of the lumbar spine, cardio-respiratory function assessment were submitted for consideration.

IMR ISSUES, DECISIONS AND RATIONALES

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

FOLLOW UP EVAL 4-6 WKS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OFFICE VISITS.

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: THORACIC & LUMBAR OFFICE VISITS; NECK AND UPPER BACK: OFFICE VISITS.

Decision rationale: MTUS does not comment on office visit. ODG recommends office visits as determined to be medically necessary. Evaluation and management outpatient visits to the offices of medical doctor play a critical role in the proper diagnosis and return to function of an injured worker, and they should be encouraged. The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The determination is also based on what medications the patient is taking, since some medicines such as opiates, or medicines such as certain antibiotics, require close monitoring. As patient conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. The determination of necessity for an office visit requires individualized case review and assessment, being ever mindful that the best patient outcomes are achieved with eventual patient independence from the health care system through self care as soon as clinically feasible. The number of automatically covered visits for shoulder, low back, or neck complaints is 6. In this case the patient had been seen for evaluation 11 times during the year. There are no anticipated major changes in the patient's treatment. In addition the the physical examination is limited to cervical and lumbar spine. Changes in therapeutic interventions are limited. There is no documentation that the patient independence from the health care system was being established. Medical necessity has not been established.

MRI LUMBAR SPINE: 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-REPEAT MRI STUDIES.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) LOW BACK - LUMBAR & THORACIC, MRI'S.

Decision rationale: MRI's are test of choice for patients with prior back surgery. MRI of the lumbar spine for uncomplicated low back pain, with radiculopathy, is not recommended until after at least one month conservative therapy, sooner if severe or progressive neurologic deficit. Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (tumor, infection, fracture, neurocompression, recurrent disc herniation). In this case the patient had received an MRI on March 25, 2011. The patient's condition was unchanged and there were no neurologic deficits. Medical necessity is not established. The request should not be authorized.

CARDIO-RESPIRATORY/ AUTONOMIC FUNCTION ASSESSMENT: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation CLINICAL TREATMENT GUIDELINES - CARDIOVASCULAR: DIAGNOSTIC TESTING.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation UPTODATE : MECHANISMS, CAUSES, AND EVALUATION OF ORTHOSTATIC HYPOTENSION EVALUATION OF THE PATIENT WITH SUSPECTED HEART FAILURE: OVERVIEW OF PULMONARY FUNCTION TESTING IN ADULTS

Decision rationale: Autonomic failure is a disorder of noradrenergic neurotransmission in which norepinephrine is not released appropriately. Subnormal epinephrine results in impaired vasoconstriction and reduced intrathoracic volume. There is an absence of an appropriate reflex-induced increase in heart rate as blood pressure falls. Assessment for heart failure is recommended when a patient presents with shortness of breath or symptoms of myocardial infarction. Pulmonary function testing is indicated for evaluation of symptoms such as chronic cough, wheezing, dyspnea, for objective assessment of bronchodilator therapy, for evaluation of effects of exposure to chemical at work, for risk evaluation of patient prior to thoracic or upper abdominal surgery, or for objective assessment of impairment or disability. In this case the patient had no symptoms or signs indicating that she was suffering from cardiac or pulmonary disease. There is no documentation of vital signs during the office visits from the requesting physician. Medical necessity has not been established. The request should not be authorized.