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| <b>Case Number:</b>   | CM14-0138685 |                              |            |
| <b>Date Assigned:</b> | 09/05/2014   | <b>Date of Injury:</b>       | 09/10/2012 |
| <b>Decision Date:</b> | 10/02/2014   | <b>UR Denial Date:</b>       | 07/30/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 08/27/2014 |

### 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 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:

According to the records made available for review, this is a 55-year-old female with a 9/10/12 date of injury. At the time (7/30/14) of the Decision for Flexion-extension studies of the lumbar spine, General Surgical consultation, Pain Management Consultation, and Psychiatric evaluation, there is documentation of subjective (neck pain, shoulder pain, elbow pain, forearm pain, right hand pain, knee pain, abdominal pain, and lower back pain; numbness and tingling of the hands and into the digits, and right lower extremity numbness into the foot) and objective (tenderness to palpation over the paracervical muscles bilaterally, decreased cervical range of motion; positive shoulder depression test; tenderness over the paralumbar muscles with decreased range of motion, positive Kemp's test; decreased shoulder range of motion; and diminished sensation over the C6 dermatome on the left upper extremity) findings, imaging findings (MRI of the lumbar spine (12/21/13) report revealed mild to moderate bilateral facet degenerative changes with mild grade 1 anterolisthesis of L4 over L5, mild to moderate degenerative endplate changes, and a 3 mm broad-based posterior disc bulge with no spinal stenosis or neural foraminal narrowing at L4-5; MRI of the cervical spine (12/21/13) report revealed moderate to severe right and moderate left neural foraminal narrowing at C4-5, and moderate left neural foraminal narrowing at C5-6), current diagnoses (right wrist carpal tunnel syndrome, thumb sprain/strain, lumbar disc syndrome, right ankle sprain/strain, right shoulder tendinosis, cervical disc syndrome, and abdominal pain), and treatment to date (cortisone injection to the shoulder, physical therapy, and medications). In addition, medical report identifies a request for general surgical consultation due to abdominal hernia; pain management consultation for possible epidural steroid injection; psychiatric evaluation due to anxiety and depression; and continue physical therapy and medications. Regarding Flexion-extension studies of the lumbar spine, there is no documentation of symptomatic spondylolisthesis and consideration for surgery.

Regarding General Surgical consultation and Pain Management Consultation, there is no documentation that consultation is indicated to aid in the diagnosis, prognosis, therapeutic management, determination of medical stability, and permanent residual loss and/or the examinee's fitness for return to work. Regarding Psychiatric evaluation, there is no documentation that a consultation will allow for screening, assessment of goals, and further treatment options.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Flex ion-extension studies of the lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation ODG, Low Back Procedure Summary

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303 and 304. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Flexion/extension imaging studies

**Decision rationale:** California Medical Treatment Utilization Schedule (MTUS) reference to American College of Occupational and Environmental Medicine (ACOEM) identifies documentation of red flag diagnoses where plain film radiographs are negative; unequivocal objective findings that identify specific nerve compromise on the neurologic examination, do not respond to treatment, and who would consider surgery, as criteria necessary to support the medical necessity of imaging. Official Disability Guidelines (ODG) identifies documentation of symptomatic spondylolisthesis when there is consideration for surgery, as criteria necessary to support the medical necessity of flexion and extension x-rays. Within the medical information available for review, there is documentation of diagnoses of right wrist carpal tunnel syndrome, thumb sprain/strain, lumbar disc syndrome, right ankle sprain/strain, right shoulder tendinosis, cervical disc syndrome, and abdominal pain. However, there is no documentation of symptomatic spondylolisthesis and consideration for surgery. Therefore, based on guidelines and a review of the evidence, the request for Flexion-extension studies of the lumbar spine is not medically necessary.

**General Surgical consultation:** 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), Office Visits

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Independent Medical Examinations and consultations, page(s) 127

**Decision rationale:** California Medical Treatment Utilization Schedule (MTUS) reference to American College of Occupational and Environmental Medicine (ACOEM) guidelines identifies that consultation is indicated to aid in the diagnosis, prognosis, therapeutic management, determination of medical stability, and permanent residual loss and/or the examinee's fitness for return to work, as criteria necessary to support the medical necessity to support the medical necessity of consultation. Within the medical information available for review, there is documentation of diagnoses of right wrist carpal tunnel syndrome, thumb sprain/strain, lumbar disc syndrome, right ankle sprain/strain, right shoulder tendinosis, cervical disc syndrome, and abdominal pain. However, despite documentation of a request for general surgical consultation due to abdominal hernia, and given no documentation of supportive clinical findings of abdominal hernia, there is no documentation that consultation is indicated to aid in the diagnosis, prognosis, therapeutic management, determination of medical stability, and permanent residual loss and/or the examinee's fitness for return to work. Therefore, based on guidelines and a review of the evidence, the request for General Surgical consultation is not medically necessary.

**Pain Management Consultation:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Independent Medical Examinations and consultations, page(s) 127

**Decision rationale:** California Medical Treatment Utilization Schedule (MTUS) reference to American College of Occupational and Environmental Medicine (ACOEM) guidelines identifies that consultation is indicated to aid in the diagnosis, prognosis, therapeutic management, determination of medical stability, and permanent residual loss and/or the examinee's fitness for return to work, as criteria necessary to support the medical necessity to support the medical necessity of consultation. Within the medical information available for review, there is documentation of diagnoses of right wrist carpal tunnel syndrome, thumb sprain/strain, lumbar disc syndrome, right ankle sprain/strain, right shoulder tendinosis, cervical disc syndrome, and abdominal pain. In addition, there is documentation of a request for pain management consultation for possible epidural steroid injection. However, given no documentation of the specific level(s) and body part to be addressed, there is no documentation that consultation is indicated to aid in the diagnosis, prognosis, therapeutic management, determination of medical stability, and permanent residual loss and/or the examinee's fitness for return to work. Therefore, based on guidelines and a review of the evidence, the request for Pain Management Consultation is not medically necessary.

**Psychiatric evaluation:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines psychological evaluations.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Psychological Evaluation Page(s): 100-102. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness & Stress, Psychological Evaluation

**Decision rationale:** Chronic Pain Medical Treatment Guidelines identifies that a consultation with a psychologist allows for screening, assessment of goals, and further treatment options, as criteria necessary to support the medical necessity of psychological evaluation. Official Disability Guidelines (ODG) identifies that psychological evaluation are well-established diagnostic procedures not only with selected use in pain problems, but also with more widespread use in subacute and chronic pain populations, as criteria necessary to support the medical necessity of psychological evaluation. Within the medical information available for review, there is documentation of diagnoses of right wrist carpal tunnel syndrome, thumb sprain/strain, lumbar disc syndrome, right ankle sprain/strain, right shoulder tendinosis, cervical disc syndrome, and abdominal pain. However, despite documentation of a request for psychiatric evaluation due to anxiety and depression, and given no documentation of supportive clinical findings of depression and anxiety, there is no documentation that a consultation will allow for screening, assessment of goals, and further treatment options. In addition, despite documentation of pain, there is no (clear) documentation of chronic pain. Therefore, based on guidelines and a review of the evidence, the request for Pain Management Consultation is not medically necessary.