

Case Number:	CM14-0155751		
Date Assigned:	09/26/2014	Date of Injury:	03/11/2010
Decision Date:	10/27/2014	UR Denial Date:	09/16/2014
Priority:	Standard	Application Received:	09/23/2014

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 Family Medicine 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:

This 41-year old woman reported a right upper extremity injury due to repetitive motion at her job in a window factory, date of injury 3/11/10. Symptoms initially involved the R elbow, forearm and wrist, but then spread to involve neck and bilateral shoulders, arms, wrists and hands. There appears to be considerable controversy as to what her diagnoses are, and as to what body parts are accepted for the claim. Per the adjuster of the claim, the only accepted body part is the right wrist. The patient was diagnosed with right carpal tunnel syndrome and had a R carpal tunnel release without improvement in her symptoms. Other diagnoses have included myofascial pain syndrome, complex regional pain syndrome (CRPS) and thoracic outlet syndrome (TOS). There are multiple AME and QME reports in the record, all of which document lack of evidence for specific entities such as CRPS or TOS, and which conclude that she has a non-specific generalized pain syndrome, probably not caused by her work. She has been followed by a chiropractor and by multiple MDs. She has had multiple tests which have included x-rays and MRIs, neurodiagnostic testing, vascular imaging and psychiatric evaluation. The current primary treater's most recent progress note documents that the patient continues to have nearly constant moderate to severe neck and back pain. There is marked tenderness and decreased range of motion of both the neck and back. Neurological exam is documented as normal. A request is made for a referral to a rheumatologist on an urgent basis. The reasons for the referral are unclear. The provider states that he explained to the patient that her symptoms are not related to her spine, and that his thought is to recommend a consultation with a local rheumatologist. He also states that her symptoms are "in both upper extremities, in both shoulders and elbows, worse on the left side". The diagnoses listed on the referral request included cervicalgia, myalgia and myositis, and back pain. The patient has not worked since shortly after her injury.

IMR ISSUES, DECISIONS AND RATIONALES

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

Consultation with an Internal Medicine Physician/Rheumatologist (Cervical): 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-TWC), Pain Procedure Summary (last updated 09/10/14), Office Visits

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment, Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 21;43;79-81.

Decision rationale: According to the guidelines cited above, determining whether a patient suffers from a pathologic condition may not always be straightforward. Some workers may believe that symptoms resulting from a lack of fit with job activities reflect physical injury or an occupational disease. When they present for evaluation, they may describe their problem as characterized by the gradual development of symptoms (primarily pain) over time or the development of symptoms after a minor physiologic stress. Often they may have multiple symptoms with nonspecific physical findings. Some health care providers may perform multiple tests and procedures to attempt to determine the source of these employees' complaints. In the absence of reproducible objective findings that are known to be work-related in population studies, an incomplete or inaccurate approach to the patient assessment may set the stage for the prolongation of medical care, delayed recovery, and later a range of behaviors that develop in order to prove that the symptoms reflect an injury or occupational disease that precludes a return to the work environment. Under the optimal system, a clinician acts as the primary case manager. The clinician provides appropriate medical evaluation and treatment and adheres to a conservative evidence-based treatment approach that limits excessive physical medicine use and referral. Nonmedical issues, once identified, need to be referred or, if possible, managed by the provider. These issues can be handled in the same way as a regular medical specialist referral. In other words, physicians need to find their comfort point and refer the situations that are beyond it. This may require developing a network of resources to call when nonmedical issues prolong disability. The clinician should judiciously select and refer to specialists who will support functional recovery as well as provide expert medical recommendations. Close communication is necessary and should emphasize the occupational health clinician's role as the primary case manager. The clinician should always think about differential diagnoses, whether they are of an occupational or non-occupational nature. This does not have to be a long process. By stepping back and reevaluating the patient and the entire clinical picture, symptoms or physical findings may be identified that have developed since the injury and that may not be consistent with the original diagnosis. A detailed history and physical examination should be conducted. Special studies may be used to determine the presence of conditions that might be helped by surgical or medical therapy more intensive or specialized than that described in these guidelines. However, the occupational health professional managing the case must be sure that the studies are indicated and are specific and sensitive for the related condition. Testing can be done to confirm clinical data. In addition, effective therapy should be available for any condition that the clinician attempts to identify. Many patients will have normal results of studies or findings consistent with age. Because an evaluation is usually successful in detecting the rare case of serious pathology, but in most cases will not find a specific cause for musculoskeletal pain, the patient may need reassurance. The clinical findings in this case do not support a referral

to a rheumatologist. This patient fits the profile described above, of a patient with multiple symptoms without specific physical findings. There is an absence of reproducible objective findings that are known to be work-related in population studies. Multiple tests and evaluations have been performed. This appears to have resulted in a range of behaviors that have developed in order to prove that the patient cannot return to work. This patient does not need another referral which will only confirm her feeling that she has serious work-related diagnoses that preclude her from returning to work. The provider has not stepped back and re-evaluated the situation, nor has he documented clear reasons for the requested referral. Multiple evaluators have concluded that this patient has a myofascial pain syndrome or an equivalent, and that she is able to work. It might be more helpful to the patient for the primary treater to assist her in returning to work rather than continuing to chase increasingly unusual and unlikely diagnoses. Based on the evidence-based references above, a consultation with an internal medicine physician/rheumatologist (neck) is not medically necessary.