

Case Number:	CM14-0179175		
Date Assigned:	11/03/2014	Date of Injury:	05/29/2010
Decision Date:	12/09/2014	UR Denial Date:	10/02/2014
Priority:	Standard	Application Received:	10/28/2014

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 54 years old dishwasher reported bilateral knee and right shoulder injuries due to slipping and falling on 5/29/10. She also had previously reported injuries to her head, neck and low back resulting from a slip and fall on 1/21/08 She has a previously documented history of fibromyalgia, irritable bowel syndrome, thyroid disease, diabetes, hypercholesterolemia, chronic fatigue syndrome, TMJ syndrome, hypertension and two left ankle surgeries in 1997. In addition, she has a history of 5 other previous Workers' Compensation claims. Treatment since 2010 has included two right shoulder surgeries, a right carpal tunnel release, and a stellate ganglion block for complex regional pain syndrome. She has had multiple physical therapy and aquatic therapy treatments. The records contain multiple documents generated by the patient's current treaters, which largely consist of requests for various diagnostic procedures, referrals and therapeutic interventions. These have included MRI's of both knees, the neck, the low back and the right shoulder; electromyography of both upper and lower extremities, psychiatric testing, a sleep study, EKG, cardiorespiratory testing, gastric emptying study, endoscopy, colonoscopy, abdominal ultrasound; referrals to neurology, internal medicine, ophthalmology, pain medicine, urology, and psychiatry; provision of Nexium, Ranitidine, Gaviscon, Victoza, metformin, diabetic supplies, gabapentin, Trazodone, topical compounded creams, and medical foods; and requests for physical therapy, shockwave therapy to both knees, and surgery for the right knee. Many of the tests, referrals and procedures have already been performed despite non-certification in UR. The records contain a report from a secondary treater dated 9/3/14. It documents no change in the patient's diabetes or gastroesophageal symptoms. The only abnormalities noted on exam include obesity, a heart rate of 104, blood glucose of 224, lumbosacral tenderness and 2+ peripheral edema of the lower extremities. No neurological or vascular exam is documented. Diagnoses include diabetes mellitus, rule out diabetic neuropathy (aggravated by industrial

injury); gastroesophageal reflux disease, secondary to NSAIDs; posttraumatic weight gain (unsubstantiated at this time); proteinuria, rule out secondary to diabetes mellitus (new diagnosis); and tachycardia, rule out secondary to anxiety (new diagnosis). A renal ultrasound, arterial and venous vascular studies, and Sudoscan (sweat testing) were ordered. The rationale provided for the vascular studies invokes ACOEM Guidelines page 89, which states that the clinician can always think about differential diagnoses and order studies that are specific and sensitive for the related conditions. It does not describe what differential diagnosis is being considered and why venous and arterial vascular studies would be specific and sensitive testing for the diagnosis. The patient remains at total disability status.

IMR ISSUES, DECISIONS AND RATIONALES

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

Vascular studies (Venous and Arterial): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management, Chapter 3 Initial Approaches to Treatment Page(s): 43-44, 79-80.

Decision rationale: A request for venous and arterial vascular studies is so non-specific that it is impossible to determine what testing is involved. This request could be for anything from a magnetic resonance venogram of the brain to arteriograms of the lower extremities. Since the request is so non-specific, it cannot be deemed medically necessary. However, there are evidence-based guidelines that apply, which the requesting physician has (rather cynically) partially cited. The ACOEM citations above state that determining whether a patient suffers from a pathologic condition may not always be straightforward. Workers may believe that they have a physical injury when the real problem is a lack of fit with their job duties. Such workers may present with the development of symptoms after a minor physiologic stress, and often may have multiple symptoms with non-specific physical findings. Performing multiple procedures and tests in this setting is described as an incomplete or inaccurate approach to patient assessment that may set the stage for the prolongation of medical care, delayed recovery and the development of a range of behaviors by the patient in order to prove that there is a real injury that precludes return to work. In cases of delayed recovery, the clinician should determine whether specific obstacles are preventing the patient from returning to work. The clinician should judiciously select and refer to specialists who will support functional recovery as well as provide medical expertise. The clinician should always think about differential diagnoses. This should involve stepping back and reevaluating the patient and the entire clinical picture. Symptoms or physical findings that have developed since the injury that may not be consistent with the original diagnosis. A detailed history and physical exam should be conducted. Appropriate studies may be performed. However, the clinician must be sure that the studies are indicated and are specific and sensitive for the related condition. In addition, effective therapy should be available for any condition that the clinician attempts to identify. The clinical information provided does not document that any of the above recommendations have occurred. There has been no careful reassessment of the patient's history and physical exam. No

consideration has been given to whether or not the patient's current findings are consistent with the original injury. No clear differential diagnoses were entertained. No functional assessment has been made beyond stating that the patient is totally disabled. Referrals have not been made to specialists who support functional recovery, and in fact the current requesting physician appears to have no interest in facilitating any functional recovery. This patient appears to be one of those described above, with multiple ongoing symptoms that are more likely to represent attempts by the patient to prove that she cannot return to work than to represent any real injury. In this setting, continuing to order multiple tests for unclear reasons is likely to do the patient harm. This kind of testing, made for the vague reasons described, is quite likely to reinforce the patient's impression that that she has multiple real work-related injuries and that she can never work again, and is also likely to stall any progress she might make toward recovery. Based on the MTUS citations above and on the clinical information provided for my review, vascular studies (venous and arterial) are not medically necessary. They are not medically necessary because it is impossible to ascertain what tests are actually being requested; because an appropriate assessment of the patient has not been made; because no clear differential diagnosis is documented; because the testing would be performed for unclear reasons and would not be specific or sensitive for a particular diagnosis; and because the continued performance of multiple tests in this case is likely to interfere with any recovery the patient might make, and thus do her harm.