

<b>Case Number:</b>	CM14-0021402		
<b>Date Assigned:</b>	05/07/2014	<b>Date of Injury:</b>	04/30/2010
<b>Decision Date:</b>	08/07/2014	<b>UR Denial Date:</b>	02/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/20/2014

### 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 Occupational 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:

The patient is a 51-year-old female who has filed a claim for cervical spine disc syndrome associated with an industrial injury date of April 30, 2010. Review of progress notes indicates pain to the neck, left shoulder, left elbow, and right knee. Patient complains of spasm, weakness, and locks with loss of range of motion of the right knee. Findings include painful range of motion of the cervical spine and right knee; tenderness over the cervical, thoracic, and lumbar spine; edema of the left arm; sensory loss of the left upper extremity; presence of trigger points in the cervical, thoracic, and lumbar spines; and positive orthopedic tests of the cervical spine, lumbar spine, left shoulder, left elbow, and right knee. Treatment to date has included sedatives, antidepressants, triptans, topiramate, GI medications, NSAIDs, chiropractic therapy, acupuncture, physical therapy, home exercises, and right knee surgeries in October 2012 and May 2013. Utilization review from February 07, 2014 denied the requests for DME trial as there was no documentation of the specific DME being requested; shockwave therapy as guidelines do not consistently support the use of this modality for musculoskeletal conditions; pain management evaluation, internal medicine consultation, and orthopedic consultation as there was no documentation that diagnostic and therapeutic management has been exhausted, and of the specific indication for these requests; and right knee brace as there is no clear documentation of a condition for which a knee brace is indicated.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**DURABLE MEDICAL EQUIPMENT (DME) TRIAL: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Anthem Guideline CG-DME-10.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg chapter, Durable medical equipment (DME).

**Decision rationale:** The CA MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, and ODG was used instead. According to ODG, durable medical equipment are recommended if there is a medical need and if the device of system meets the definition of durable medical equipment - equipment that can withstand repeated use, is primarily and customarily used to serve a medical purpose, is not useful to a person in the absence of illness or injury, and is appropriate for use in a patient's home. There is no documentation of the specific DME requested, or the specific indication for which this is requested. Therefore, the request for DME trial was not medically necessary.

**SHOCKWAVE THERAPY:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Elbow chapter, Extracorporeal shockwave therapy (ESWT).

**Decision rationale:** The CA MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, and ODG was used instead. According to ODG, extracorporeal shockwave therapy is not recommended for the elbow. There is no indication regarding failure of conservative management, the body part, or the indication for shockwave therapy. Therefore, the request for shockwave therapy was not medically necessary.

**PAIN MANAGEMENT EVALUATION:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM) pg. 127 and Official Disability Guidelines (ODG), Low Back Chapter.

**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 chapter, pages 127 and 156.

**Decision rationale:** As stated on pages 127 and 156 of the ACOEM Independent Medical Examinations and Consultations Guidelines referenced by CA MTUS, occupational health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. This patient had pain management evaluation in August 2013 for pain in the neck, left arm, left elbow, left wrist, and right knee. Patient was given Ultracet to take on an as-needed basis. The primary physician notes that the patient is progressing slower than expected, with 60% improvement. However, there is no documentation of new findings or significant worsening of the patient's condition, or that the primary physician has tried and failed conservative management strategies to support another pain management evaluation at this time. Therefore, the request for pain management evaluation was not medically necessary.

**INTERNAL MEDICINE CONSULTATION:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM) pg. 127 and Official Disability Guidelines (ODG), Low Back Chapter.

**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 chapter, pages 127 and 156.

**Decision rationale:** As stated on pages 127 and 156 of the ACOEM Independent Medical Examinations and Consultations Guidelines referenced by CA MTUS, occupational health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. The patient has previously been seen by internal medicine for vertigo, headaches, constipation, but mainly for insomnia and gastritis. Urea breath testing was positive, and patient was started on H. pylori medications on November 25, 2013. Latest internal medicine visit in January 2014 indicated that the patient's medications were Zoloft, Ambien, Prilosec, Provigil, Amoxicillin, Ibuprofen, and Ultracet. Patient was started on Topamax. At this time, a follow-up consultation with the internal medicine physician is necessary to check whether the gastritis symptoms have resolved, and to assess the effects of therapy with Topamax. Therefore, the request for internal medicine consultation was medically necessary.

**ORTHOPEDIC CONSULTATION:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM) pg. 127 and Official Disability Guidelines (ODG), Low Back Chapter.

**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 chapter, pages 127 and 156.

**Decision rationale:** As stated on pages 127 and 156 of the ACOEM Independent Medical Examinations and Consultations Guidelines referenced by CA MTUS, occupational health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. This patient had an orthopedic consult for left elbow pain in 2013, with recommendation to seek pain management and spine specialist consultation. Patient does not present with new-onset symptoms at this time to warrant another orthopedic consultation. Therefore, the request for orthopedic consultation was not medically necessary.

**RIGHT KNEE BRACE:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg chapter, Knee brace.

**Decision rationale:** The CA MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, and ODG was used instead. According to ODG, criteria for use prefabricated knee braces include knee instability, ligament insufficiency/deficiency, reconstructed ligament, articular defect repair, avascular necrosis, meniscal cartilage repair, painful failed total knee arthroplasty, painful high tibial osteotomy, painful unicompartmental osteoarthritis, and tibial plateau fracture. Custom fabricated knee braces may be used in patients with abnormal limb contour, skin changes, severe osteoarthritis, maximal off-loading of painful or repaired knee compartment, or severe instability. In this case, the patient is status post right knee surgeries (unspecified) in October 2012 and May 2013. There is no clear documentation of right knee instability or of the indication for right knee bracing. Additional information is necessary to support this request. Therefore, the request for right knee brace was not medically necessary.