

Case Number:	CM14-0068246		
Date Assigned:	08/08/2014	Date of Injury:	08/23/2013
Decision Date:	05/05/2015	UR Denial Date:	04/10/2014
Priority:	Standard	Application Received:	05/12/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: New York

Certification(s)/Specialty: Emergency Medicine

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 injured worker is a 58 year old female who sustained an industrial injury on 08/23/2013. Diagnoses include thoracic strain, neck sprain/strain, brachial neuritis /radiculitis and lumber strain/sprain. Treatment to date has included diagnostic testing, medications, and physical therapy. A physician progress note dated 03/13/2014 documents the injured worker complained of upper, mid and lower back pain. Examination showed increased tenderness and decreased range of motion of the spine. A physician progress note dated 4/10/2014 documents the injured worker complains of intermittent, moderate dull, achiness pain radiating to the left arm with numbness. She has intermittent, moderate dull, achiness in the upper, mid back, and low back pain. There is +3 tenderness to palpation of the lumbar, thoracic and cervical paravertebral muscles, and muscle spasm is present in the lumbar, thoracic, and cervical paravertebral muscles. Treatment requested is for adrenergic beat to beat blood pressure responses to the Valsalva Maneuver Sustained hand grip and BP and HR responses to active standing, Cardio vagal Innervation and Heart Rate variability (parasympathetic Innervation), EMG Bilateral upper extremities and Nerve conduction studies, Functional Capacity Evaluation, Medication Consult, Physical Therapy x 3-4wks x4weeks, Sleep Disorder Breathing Respiratory with overnight Pulse Oximetry and Nasal Function, Spirometry and Pulmonary Function Test, Sudoscan, and X rays of the lumbar, cervical and thoracic spine. On 04/10/2014 non-certified the request for adrenergic beat to beat blood pressure responses to the Valsalva Maneuver Sustained hand grip and BP and HR responses to active standing is non-certified and considered investigational and not medically necessary for all indications. Cardio vagal Innervation and Heart Rate variability

(parasympathetic Innervation), is non-certified and considered investigational and is not medically necessary for all indications. EMG Bilateral upper extremities and Nerve conduction studies are not certified. There are no symptoms or findings suggestive of a focal neuropathy failing conservative management to support the medical necessity of electrodiagnostic testing. Functional Capacity Evaluation was non-certified and cited was Official Disability Guidelines. Medication Consult and American College of Occupational and Environmental Medicine (ACOEM). Physical Therapy x 3-4wks x4weeks was non-certified and cited was California Medical Treatment Utilization Schedule (MTUS)-Chronic Pain Medical Treatment Guidelines. Sleep Disorder Breathing Respiratory with overnight Pulse Oximetry and Nasal Function in not certified and cited was Official Disability Guidelines. Spirometry and Pulmonary Function Test was non-certified and Official Disability Guidelines was cited. Sudoscan was non-certified. It is considered investigational and not medically necessary for all indications. X-rays of the lumbar, cervical and thoracic spine are non-certified. There are no red flags, recent trauma or another clear indication for imaging at this point. Cited in this decision was California Medical Treatment Utilization Schedule (MTUS)-Chronic Pain Medical Treatment Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Spirometry and Pulmonary Function Test: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Pulmonary Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pulmonary chapter, Pulmonary function testing.

Decision rationale: The MTUS does not address pulmonary function testing. The Official Disability Guidelines provides specific recommendations for the diagnosis and management of chronic lung diseases including asthma and for evaluation pre-operatively for individuals with known pulmonary compromise. The treating physician has provided no indications and no specific lung diseases or diagnoses for which pulmonary function testing is indicated. Therefore, the request is not medical necessity for these tests.

Sleep Disorder Breathing Respiratory w Overnight Pulse Oximetry and Nasal Function Studies: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Pain Chapter Polysomnography.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain chapter, Polysomnography and Other Medical Treatment Guidelines Practice Parameters for the

Indications for Polysomnography and Related Procedures: An Update for 2005. SLEEP 2005;28(4):499-521.

Decision rationale: The treating physician provided no patient-specific indications for this test and did not discuss any sleep disorders or pulmonary disease. For the purposes of this review, it is presumed that this request refers to a form of a sleep study. The MTUS does not provide direction for evaluating or treating sleep disorders. The American Academy of Sleep Medicine (AASM) has published practice parameters for polysomnography (PSG) and related procedures. The conditions addressed included sleep related breathing disorders, other respiratory disorders, narcolepsy, parasomnias and sleep related seizure disorders, restless legs syndrome and periodic limb movement sleep disorder, depression with insomnia and circadian rhythm sleep disorders. The initial evaluation should include a thorough sleep history and a physical examination that includes the respiratory, cardiovascular and neurologic systems. The general evaluation should serve to establish a differential diagnosis of SRBDs, which can then be used to select the appropriate test(s). The general evaluation should therefore take place before any PSG is performed. The Official Disability Guidelines recommend polysomnography under some circumstances, including: "Excessive daytime somnolence; Sleep-related breathing disorder or periodic limb movement disorder is suspected; & Insomnia complaint for at least six months (at least four nights of the week), unresponsive to behavior intervention and sedative/sleep-promoting medications and psychiatric etiology has been excluded. A sleep study for the sole complaint of snoring, without one of the above mentioned symptoms, is not recommended." The treating physician has not provided sufficient indications for this study in light of the published guidelines and medical evidence. There is no evidence of a thorough medical evaluation that establishes the presence of all relevant medical conditions. The recommended prior conservative care prior to ordering a sleep study, per the Official Disability Guidelines, has not been completed. A sleep study is not medically necessary based on lack of sufficient medical evaluation and the lack of sufficient current indications.

Cardiovagal Innervation and Heart Rate variability (parasympathetic Innervation):
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 Up-To-Date, Evaluation of heart rate variability.

Decision rationale: The treating chiropractor has not provided any patient-specific indications for this test. The MTUS does not address this kind of testing. The Up-To-Date citation above discusses the role of the autonomic nervous system in the context of heart disease, which appears to be the purported context for testing in this patient. The indications for this kind of testing, per the available evidence, are two: prediction of risk of cardiac death or arrhythmic events post-myocardial infarction (MI), and detection and quantification of autonomic neuropathy in patients with diabetes mellitus. Neither of these conditions was described in this injured worker. This test is therefore not medically necessary.

Adrenergic beat to beat blood pressure responses to the Valsalva Manuever Sustained hand grip and BP and HR responses to active standing: 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 Up-To-Date, Evaluation of heart rate variability.

Decision rationale: The treating chiropractor has not provided any patient-specific indications for this test. The MTUS does not address type of testing. The Up-To-Date citation above discusses the role of the autonomic nervous system in the context of heart disease, which appears to be the purported context for testing in this patient. The indications for this kind of testing, per the available evidence, are two: prediction of risk of cardiac death or arrhythmic events post-myocardial infarction (MI), and detection and quantification of autonomic neuropathy in patients with diabetes mellitus. Neither of these conditions was described in this injured worker nor are factors supporting the request. This test is therefore not medically necessary.

EMG/NCS Bilateral upper extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 182; 168-171; 196-201; 213; 268; 272.

Decision rationale: There are no reports from the prescribing physician which adequately present the neurologic findings leading to medical necessity for electrodiagnostic testing. Non-specific pain or paresthesias are not an adequate basis for performance of EMG or NCV. Medical necessity for electrodiagnostic testing is established by a clinical presentation with a sufficient degree of neurologic signs and symptoms to warrant such tests. Non-specific, non-dermatomal extremity symptoms are not sufficient alone to justify electrodiagnostic testing. The MTUS, per the citations listed above, outlines specific indications for electrodiagnostic testing, and these indications are based on specific clinical findings. The physician should provide a diagnosis that is likely based on clinical findings, and reasons why the test is needed. The clinical evaluation is minimal and there is no specific neurological information showing the need for electrodiagnostic testing. For example, a diagnosis of radiculopathy should be supported by the signs and symptoms listed in the MTUS cited above. Based on the recent clinical information, there are no neurologic abnormalities and no specific neurologic symptoms. Based on the current clinical information, electrodiagnostic testing is not medically necessary, as the treating physician has not provided the specific indications and clinical examination outlined in the MTUS.

X-rays of Cervical Spine: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177; 182.

Decision rationale: The ACOEM Guidelines 2nd Edition portion of the MTUS provides direction for performing imaging of the spine. Per the MTUS citation above, imaging studies are recommended for "red flag" conditions, physiological evidence of neurological dysfunction, and prior to an invasive procedure. This injured worker had no objective evidence of any of these conditions or indications for an invasive procedure. The treating physician has not documented any specific neurological deficits or other signs of significant pathology. Per the MTUS, imaging is not generally necessary absent a 3-4 week period of conservative care. The treating physician did not describe an adequate course of conservative care prior to prescribing an imaging study. Ongoing pain or non-specific radiating symptoms do not constitute a sufficient basis for imaging. The radiographs are not medically necessary based on the recommendations in the MTUS.

X-rays of Thoracic Spine: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177; 182.

Decision rationale: The ACOEM Guidelines 2nd Edition portion of the MTUS provides direction for performing imaging of the spine. Per the MTUS citation above, imaging studies are recommended for "red flag" conditions, physiological evidence of neurological dysfunction, and prior to an invasive procedure. This injured worker had no objective evidence of any of these conditions or indications for an invasive procedure. The treating physician has not documented any specific neurological deficits or other signs of significant pathology. Per the MTUS, imaging is not generally necessary absent a 3-4 week period of conservative care. The treating physician did not describe an adequate course of conservative care prior to prescribing an imaging study. Ongoing pain or non-specific radiating symptoms do not constitute a sufficient basis for imaging. The radiographs are not medically necessary based on the recommendations in the MTUS.

X-Rays of Lumbar Spine: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303; 290. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back chapter, radiography.

Decision rationale: The treating physician has not described the clinical evidence of significant pathology discussed in the MTUS, such as "Unequivocal objective findings that identify specific nerve compromise on the neurological examination." No 'red flag' conditions are identified. The

treating physician has not provided an adequate clinical evaluation, as outlined in the MTUS ACOEM Guidelines Pages 291-296. Per the Official Disability Guidelines citation above, imaging for low back pain is not beneficial in the absence of specific signs of serious pathology. The treating physician has not provided specific indications for performing radiographs. This patient does not fit the MTUS criteria for invasive procedures, such as epidural steroid injection or spine surgery, regardless of any proposed radiographic findings. Radiographs of the lumbar spine are not indicated in light of the paucity of clinical findings suggesting any serious pathology; increased or ongoing pain, with or without radiation, is not in itself indication for imaging. Radiographs of the lumbar spine are not medically necessary based on lack of sufficient indications per the MTUS.

Medication Consult: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines approach to medications for chronic pain Page(s): 7-8.

Decision rationale: The treating chiropractor has not provided any specific indications for this referral. The MTUS, per the citation above, discusses the indications for medications to treat chronic pain and the variables that should be considered. There is no discussion of an approach based on functional improvement. The medication prescribing that has occurred in this case has been far outside of the recommendations of the MTUS and the FDA. The treating chiropractor has not made an adequate case for this referral in light of the specific patient factors and the MTUS recommendations. The referral is therefore not medically necessary.

Functional Capacity Evaluation: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Functional Capacity Evaluation.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 81, Chronic Pain Treatment Guidelines Work conditioning, work hardening Page(s): 126. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Fitness for Duty chapter, Functional capacity evaluation and Other Medical Treatment Guidelines ACOEM), 2nd Edition, (2004) Chapter 7, Pages 137-8, discussion of IME recommendations (includes functional capacity evaluation).

Decision rationale: The ACOEM guidelines pages 137-8, in the section referring to Independent Medical Evaluations (which is not the context in this case), state "there is little scientific evidence confirming that functional capacity evaluations predict an individual's actual capacity to perform in the workplace and it is problematic to rely solely upon the functional capacity evaluation results for determination of current work capability and restrictions." The MTUS for Chronic Pain and the Official Disability Guidelines recommend a functional capacity

evaluation for Work Hardening programs, which is not the context in this case. The Official Disability Guidelines state that a functional capacity evaluation is "Recommended prior to admission to a Work Hardening (WH) Program, with preference for assessments tailored to a specific task or job. Not recommend routine use as part of occupational rehab or screening, or generic assessments in which the question is whether someone can do any type of job generally." The current request does not meet this recommendation, as it appears to be intended for general rather than job-specific use. The treating physician has not defined the components of the functional capacity evaluation. Given that there is no formal definition of a functional capacity evaluation, and that a functional capacity evaluation might refer to a vast array of tests and procedures, medical necessity for a functional capacity evaluation (assuming that any exists), cannot be determined without a specific prescription which includes a description of the intended content of the evaluation. The MTUS for Chronic Pain, in the Work Conditioning-Work Hardening section, mentions a functional capacity evaluation as a possible criterion for entry, based on specific job demands. The treating physician has not provided any information in compliance with this portion of the MTUS. The functional capacity evaluation in this case is not medically necessary based on lack of medical necessity and lack of a sufficiently specific prescription.

Physical Therapy x3-4wks x4weeks: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178, Chronic Pain Treatment Guidelines Manual Therapy and Manipulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Introduction, functional improvement. Physical Medicine Page(s): 9, 98-99.

Decision rationale: The treating physician has not provided an adequate prescription, which must contain diagnosis, duration, frequency, and treatment modalities, at minimum. Per the MTUS, Chronic Pain section, functional improvement is the goal rather than the elimination of pain. The maximum recommended quantity of Physical Medicine visits is 10, with progression to home exercise. The treating physician has not stated a purpose for the current physical therapy prescription. It is not clear what is intended to be accomplished with this physical therapy, given that it will not cure the pain and there are no other goals of therapy. The current physical therapy prescription exceeds the quantity recommended in the MTUS (up to 10 visits). The specific body parts to be treated are not listed. No medical reports identify specific functional deficits, or functional expectations for Physical Medicine. The Physical Medicine prescription is not sufficiently specific, and does not adequately focus on functional improvement. Given the completely non-specific prescription for physical therapy in this case, it is presumed that the therapy will use passive modalities. The MTUS recommends against passive modalities for chronic pain. Physical Medicine is not medically necessary based on the MTUS, lack of sufficient emphasis on functional improvement, lack of a sufficient prescription, and a prescription in excess of the quantity recommended in the MTUS.

Sudoscan: 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 Up-To-Date, Etiology, clinical manifestations, and diagnosis of complex regional pain syndrome in adults. Diabetic autonomic neuropathy.

Decision rationale: The treating physician did not provide clinical information and patient-specific information to support this test. According the reports, this test is for sudomotor function assessment. The MTUS does not address this kind of testing. Although the treating physician did not address the patient-specific indications for this test, it is possible that it was prescribed for assessment of CRPS. The reports also mention diabetic neuropathy. The Up-To-Date references above discuss the use of this kind of autonomic testing in the context of CRPS and diabetes. None of the clinical factors associated with CRPS and diabetes were described in this case and the treating physician did not discuss the indications for any test used for CRPS or diabetes. Any other possible indications for this test in this injured worker are speculative as well. The test is not medically necessary based on the available clinical information and the cited guidelines.

Stress Test: 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 Up-To-Date, Selecting the optimal cardiac stress test.

Decision rationale: The treating chiropractor has not provided any specific indications for this test, or specified what kind of stress test is intended. The medical necessity for a stress test depends on the indications, which are discussed in the citation above, and none of which were provided by the chiropractor. Assuming indications for a stress test, there are several kinds of stress tests, each of which has specific indications. The chiropractor did not identify a specific kind of stress test or indications for a specific kind of test. Given the lack of a relevant cardiac history, the lack of specific indications for stress testing in general, and the guideline recommendations, the stress test is not medically necessary.

EKG: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0004319>.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Up-To-Date, Screening for coronary heart disease.

Decision rationale: The treating physician has not provided the specific indications for the EKG. There are many possible indications. One of the possible EKG applications is as a

screening test for heart disease, as per the guideline cited above. The treating physician has not provided the indications for the EKG as a screening test per this guideline or any other guidelines. With the available information, the EKG is not medically necessary.