

Case Number:	CM15-0105406		
Date Assigned:	06/09/2015	Date of Injury:	10/10/2011
Decision Date:	07/14/2015	UR Denial Date:	05/07/2015
Priority:	Standard	Application Received:	06/01/2015

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: Anesthesiology

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 48-year-old female, who sustained an industrial injury on October 10, 2011. She reported right upper extremity pain, shoulder pain, neck pain, low back pain, knee pain and wrist and hand pain after catching her hand in a blender at work. She also reported harassment and stress at work. The injured worker was diagnosed as having, major depressive disorder, generalized anxiety disorder, lumbar spine discopathy, right knee internal derangement, cervical spine sprain/strain, bilateral carpal tunnel syndrome, bilateral hand sprain/strain, feet sprain/strain, left knee sprain/strain and complex regional pain syndrome. Treatment to date has included diagnostic studies, spinal cord stimulator placement, conservative care, medications and work restrictions. Currently, the injured worker complains of right upper extremity pain, shoulder pain, neck pain, low back pain, knee pain and wrist and hand pain with associated tingling and numbness radiating down the right arm into the right elbow and hand. The injured worker reported an industrial injury in 2011, resulting in the above noted pain. She was treated conservatively without complete resolution of the pain. Evaluation on June 12, 2014, revealed continued pain as noted. It was noted she could not tolerate the pain any longer and was noted to be a surgical candidate for the right shoulder. Evaluation on May 1, 2015, revealed continued pain as noted. Chiropractic care and acupuncture therapy were recommended. It was noted she was scheduled for permanent spinal cord stimulator placement. Acupuncture, chiropractic care, consultations with an internist, neurology and psychology and ophthalmology and a polysomnogram were requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

Acupuncture, twice a week for six weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The California MTUS Acupuncture guidelines apply to all acupuncture requests, for all body parts and for all acute or chronic, painful conditions. According to the Acupuncture Medical Treatment Guidelines, acupuncture is used as an option when pain medication is reduced or not tolerated. It may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten recovery. The treatment guidelines support acupuncture treatment to begin as an initial treatment of 3-6 sessions over no more than two weeks. If functional improvement is documented, as defined by the guidelines further treatment will be considered. In this case, the requested acupuncture sessions (2 sessions/week for 6 weeks) exceed the recommended 3-6 sessions in up to 2 weeks. Medical necessity of the requested acupuncture has not been established. The requested services are not medically necessary.

Chiropractic once a week for six weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and manipulation.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints, Chapter 9 Shoulder Complaints, Chapter 12 Low Back Complaints Page(s): 203, 298-299, Chronic Pain Treatment Guidelines Manual Therapy/Chiropractic therapy Page(s): 58-60. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chiropractic Manipulation.

Decision rationale: According to MTUS, Manual Therapy or Chiropractic therapy is recommended for chronic pain if it is caused by musculoskeletal conditions. The intended goal or effect is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. For the treatment of low back pain, a trial of 6 visits is recommended over 2 weeks, with evidence of objective improvement, with a total of up to 18 visits over 6-8 weeks. If manipulation has not resulted in functional improvement in the first one or two weeks, it should be stopped and the patient reevaluated. In this case, the patient has a date of injury from 2011. There is limited information submitted detailing her prior care and response to prior care. In addition, there is no evidence that a significant exacerbation has occurred. Of note, the request included the bilateral wrists and hands, which are "not recommended" per the MTUS. Medical necessity for the requested services has not been established. The requested services are not medically necessary.

Polysomnogram: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Treatment in Workers' Compensation, Pain Procedure Summary, Polysomnogram.

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

Decision rationale: A polysomnogram measures bodily functions during sleep, including brain waves, heart rate, nasal and oral breathing, sleep position, and levels of oxygen saturation. Polysomnography is recommended after at least six months of an insomnia complaint (at least four nights a week), unresponsive to behavior intervention and sedative/sleep-promoting medications, and after psychiatric etiology has been excluded. It is not recommended for the routine evaluation of transient insomnia, chronic insomnia, or insomnia associated with psychiatric disorders. Polysomnography/sleep studies are recommended for the combination of indications listed below: (1) Excessive daytime somnolence; (2) Cataplexy (muscular weakness usually brought on by excitement or emotion, virtually unique to narcolepsy); (3) Morning headache (other causes have been ruled out); (4) Intellectual deterioration (sudden, without suspicion of organic dementia); (5) Personality change (not secondary to medication, cerebral mass or known psychiatric problems); (6) Sleep-related breathing disorder or periodic limb movement disorder is suspected; (7) 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. (8) Unattended (unsupervised) home sleep studies for adult patients are appropriate with a home sleep study device with a minimum of 4 recording channels (including oxygen saturation, respiratory movement, airflow, and EKG or heart rate). In this case, there is no recent documentation indicating the patient's current sleep disturbance and sleep history including hours of sleep, sleep hygiene, nocturnal awakenings, and daytime sleepiness. Therefore, medical necessity for this service has not been established. The requested service is not medically necessary.

Consultation Neurologist: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Treatment in Workers' Compensation, Evaluation and Management.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, Chapter 7, Independent Medical Examinations and Consultations/Referrals, page 127.

Decision rationale: According to the CA MTUS/ACOEM, a consultation is indicated to aid in the diagnosis, prognosis, and therapeutic management, determination of medical stability, and permanent residual loss and/or, the injured worker's fitness to return to work. In this case, there is no specific rationale identifying the medical necessity of the requested Neurology consultation

for the evaluation of headaches. A recent medical report does not have any documentation of complaints of headaches. There is also no documentation that diagnostic and therapeutic management have been exhausted within the present treating provider's scope of practice. Medical necessity for the requested service has not been established. The requested service is not medically necessary.

Consultation Psychiatrist: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Psychological Evaluations Page(s): 100 and 101.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, Chapter 7, Independent Medical Examinations and Consultations/Referrals, page 127.

Decision rationale: According to the CA MTUS/ACOEM, a consultation is indicated to aid in the diagnosis, prognosis, and therapeutic management, determination of medical stability, and permanent residual loss and/or, the injured worker's fitness to return to work. In this case, there is no specific rationale identifying the medical necessity for the requested Psychiatry consultation. There is limited evidence of any current significant psychological complaints aggravated by the current injury that causes functional limitations and deficits. There is also no documentation that diagnostic and therapeutic management have been exhausted within the present treating provider's scope of practice. Medical necessity for the requested service has not been established. The requested service is not medically necessary.

Consultation Internist: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Treatment in Workers' Compensation, Pain Procedure Summary.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, Chapter 7, Independent Medical Examinations and Consultations/Referrals, page 127.

Decision rationale: According to the CA MTUS/ACOEM, a consultation is indicated to aid in the diagnosis, prognosis, and therapeutic management, determination of medical stability, and permanent residual loss and/or, the injured worker's fitness to return to work. In this case, there is no specific rationale identifying the medical necessity for the requested Internal Medicine consultation for the respiratory system. There is limited evidence of any new or current significant respiratory issues aggravated by the current injury that causes functional limitations. There are limited clinical findings signifying the need for this consultation. In addition, there is no documentation that diagnostic and therapeutic management have been exhausted within the present treating provider's scope of practice. Medical necessity for the requested service has not been established. The requested service is not medically necessary.

Consultation Ophthalmologist: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Treatment in Workers' Compensation, Eye Procedure Summary.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, Chapter 7, Independent Medical Examinations and Consultations/Referrals, page 127.

Decision rationale: According to the CA MTUS/ACOEM, a consultation is indicated to aid in the diagnosis, prognosis, and therapeutic management, determination of medical stability, and permanent residual loss and/or, the injured worker's fitness to return to work. In this case, there is no specific rationale identifying the medical necessity for the requested ophthalmology consultation. There is no documentation that indicates complaints pertaining to the eye or complaints affecting vision. Medical necessity for the requested service has not been established. The requested service is not medically necessary.