

Case Number:	CM15-0164081		
Date Assigned:	09/10/2015	Date of Injury:	09/10/2014
Decision Date:	10/13/2015	UR Denial Date:	07/27/2015
Priority:	Standard	Application Received:	08/21/2015

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: Tennessee, Florida, Ohio
 Certification(s)/Specialty: Surgery, Surgical Critical Care

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 45 year old male who sustained an industrial injury on 09-10-2014. Mechanism of injury occurred when his right knee struck the open door of a cage and he sustained injuries to his right knee. Diagnoses include right knee internal derangement, right knee sprain-strain, fatigue, loss of sleep, stress, myofascitis-myalgia, muscle spasm and weakness. Physician progress notes dated 04-03-2015 to 07-09-2015 documents the injured worker has complaints of constant, moderate throbbing right knee pain and stiffness. He also complains of tingling and weakness. He has an antalgic gait and has a moderate and severe limp. There is tenderness to palpation of the anterior, lateral, medial and posterior knee and superior border of patella. There is muscle spasm present. McMurray's and Bounce Home are positive. He has loss of sleep due to pain and his prolonged pain is causing stress. He has tenderness to palpation of the right knee and range of motion is restricted, and painful. On 07-09-2015, the injured worker rated his pain as 5 out of 10 on the Visual Analog Scale. Treatment to date has included diagnostic studies, 8 chiropractic sessions, 10 sessions of acupuncture, and physical therapy. On 07-27-2015 the Utilization Review non-certified the requested treatment Solace multi-stim unit (electrodes 8 pair/month, lead wires x 2, adaptor) x 5 months due to the medical records do not establish what type of stimulation is included in the request, and many of which are not recommended. Sleep study was non-certified. A sleep study for the sole complaint of snoring is not recommended. In addition, there is documentation that the injured worker is reporting loss of sleep due to pain. This would not be an indication for a sleep study. Pain management-medical evaluation 1 x per month was modified to pain management-

evaluation 1 x only to allow the patient a pain management consultation. Pending careful evaluation of the consultation further recommendation may be forthcoming. Internal medicine referral does not note specific pulmonary or respiratory complaints under the subjective complaints section. As such, the medical necessity for this referral appears to be unsubstantiated. Chiropractic treatment and physical therapy 1 x 4 for the right knee was non-certified. In the absence of functional improvement, additional treatment in this regard would not be indicated. Bio-behavior therapy was non-certified as listed on the request for authorization is not clear. Given the patient's current subjective complaints, it may be reasonable to allow a psychological consultation. However, this is not the request as per the request of authorization from the treating chiropractor dated 06-19-2015. Acupuncture 2 x 6 for the right knee was non-certified. He has already completed 10 session of acupuncture, and a trial of 3-6 sessions is appropriate to determine efficacy. There is no functional improvement as a result of previous treatment.

IMR ISSUES, DECISIONS AND RATIONALES

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

Acupuncture 2 x 6 for the right knee: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment 2007.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment 2007.

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of acupuncture testing for this patient. The California MTUS Acupuncture guidelines address the topic of knee acupuncture. In accordance with California MTUS Acupuncture guidelines "Frequency and duration of acupuncture or acupuncture with electrical stimulation may be performed as follows: (1) Time to produce functional improvement: 3 to 6 treatments. (2) Frequency: 1 to 3 times per week. (3) Optimum duration: 1 to 2 months. (d) Acupuncture treatments may be extended if functional improvement is documented." This patient has been prescribed acupuncture x6 to the right knee. However, the patient has already received 10 weeks of acupuncture with no functional improvement. The patient is still documented as partially disabled with chronic pain in the right knee. Based on MTUS guidelines, a trial of acupuncture has failed with no function improvement, further acupuncture is clinically inappropriate. Therefore, based on the submitted medical documentation, the request for acupuncture testing is not medically necessary.

Chiropractic treatment and physical therapy 1 x 4 for the right knee: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

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

Decision rationale: There is sufficient clinical information provided to justify the medical necessity of this type therapy for this patient. The California MTUS guidelines and the ACOEM Guidelines do not address the topic of preoperative lab testing. According to the Official Disability Guidelines (ODG), chiropractic therapy for the knee is: "Not recommended. There are no studies showing that manipulation is proven effective for patients with knee and leg complaints." This patient has been requested to receive physical therapy and chiropractic therapy for the knee in 4 sessions. ODG does not recommend this type therapy. Therefore, medical necessity for chiropractic treatment and physical therapy 1 x 4 for the right knee has not been established. The request is not medically necessary.

Bio-behavior therapy: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Psychological evaluations.

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of this request for this patient. The California MTUS guidelines address the issue of a psychology referral by stating: "It is recommended that common psychiatric conditions, such as mild depression, be referred to a specialist after symptoms continue for more than six to eight weeks. Issues regarding work stress and person-job fit may be handled effectively with talk therapy through a psychologist or other mental health professional." This patient has been documented to have a history of anxiety. Although it may be reasonable to permit a psychological referral, the request submitted was for bio-behavioral therapy. It is unclear what type of therapy this may entail. As such, the therapy is contraindicated without a clear indication of goals of treatment and treatment plan. Therefore, based on the submitted medical documentation, the request for bio-behavior therapy is not medically necessary.

Sleep study: Upheld

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

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

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of a sleep study for this patient. The California MTUS guidelines and the ACOEM Guidelines do not address the topic of preoperative lab testing. According to the Official Disability Guidelines (ODG), a sleep study 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."

Additionally, ODG states that sleep studies are: "Not recommended for the routine evaluation of transient insomnia, chronic insomnia, or insomnia associated with psychiatric disorders." Regarding this patient's case, there is no documentation of this patient's insomnia being unresponsive to behavioral intervention and sleep promoting medications. Likewise, the patient's sleep disorder has not been documented as present for greater than six months. Therefore, a sleep study is not medically necessary.

Internal medicine referral: Upheld

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

MAXIMUS guideline: Decision based on MTUS General Approaches 2004, Section(s): General Approach to Initial Assessment and Documentation, Initial Approaches to Treatment.

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of this referral for this patient. The California MTUS guidelines address the topic of specialist consultation by stating: "Referral is indicated in cases where the health care provider has a lack of training in managing the specific entity, is uncertain about the diagnosis or treatment plan, or red flags are present. If significant symptoms causing self-limitations or restrictions persist beyond 4-6 weeks, referral for specialty evaluation (e.g., occupational medicine, physical medicine and rehabilitation, or orthopedic surgery) may be indicated to assist in the confirmation of the provisional diagnosis and to define further clinical management." The medical records document that this had not specific pulmonary or cardiovascular symptoms when he was last evaluated in June of 2015. Without specific signs or symptoms of disease, a referral for pulmonary and cardiac management by an internal medicine specialist is not indicated in this case. Therefore, based on the submitted medical documentation, the request for an internal medicine consultation is not-medically necessary.

Pain management/medical evaluation 1 x per month: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Introduction.

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of pain management referral for this patient. Per MTUS, "Patients not responding to initial or subacute management or those thought to be at risk for delayed recovery should be identified as early as possible." This patient has been demonstrated to have failed multiple modalities at pain control including acupuncture, chiropractor, medication and physical therapy. The patient reports insomnia secondary to chronic pain. He has been partially disabled secondary to his chronic pain and joint complaints. Referral for pain management evaluation has

the potential to allow for functional improvement with adequate pain control. Therefore, based on the submitted medical documentation, the request for pain management referral is medically necessary.

Solace multi-stim unit (electrodes 8 pair/month, leadwires x 2, adaptor) x 5 months: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of a multi-stim unit for this patient. The California MTUS guidelines recommend the following regarding criteria for TENS unit use: 1. Chronic intractable pain (for the conditions noted above): Documentation of pain of at least three months duration. 2. There is evidence that other appropriate pain modalities have been tried (including medication) and failed. A one-month trial period of the TENS unit should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function; rental would be preferred over purchase during this trial. 3. Other ongoing pain treatment should also be documented during the trial period including medication usage. 4. A treatment plan including the specific short- and long-term goals of treatment with the TENS unit should be submitted. 5. A 2-lead unit is generally recommended; if a 4-lead unit is recommended, there must be documentation of why this is necessary. This patient's case does not meet the recommended criteria since no treatment plan (that includes short and long-term goals) was submitted. There is also no documentation that other treatment modalities have been tried and failed. Therefore, based on the submitted medical documentation, the request for Solace multi-stim unit is not-medically necessary.