

Case Number:	CM15-0192308		
Date Assigned:	10/06/2015	Date of Injury:	07/20/2015
Decision Date:	12/10/2015	UR Denial Date:	08/28/2015
Priority:	Standard	Application Received:	09/30/2015

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, California
 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 43 year old female, who sustained an industrial-work injury on 7-20-15. A review of the medical records indicates that the injured worker is undergoing treatment for right shoulder strain and sprain with impingement, tendinitis, cervical strain and sprain, right carpal tunnel syndrome, bilateral knee strain and sprain, right elbow lateral epicondylitis, lumbar radiculitis, severe depressive disorder and sleep disorder. Medical records (Doctor's First Report) dated 7-24-15 indicate that the injured worker complains of constant severe radiating right shoulder pain with pulling tightness, tingling, numbness and burning sensation. There is constant severe radiating sharp neck pain described as stabbing, pulling, burning and tight. There is constant severe radiating right hand and wrist pain with pulling, tingling, and burning with numbness sensation. There is constant severe right and left elbow pain with tightness, pulling, tingling and burning sensations. There is constant moderate right and left sharp knee pain with stabbing sensations. She also reports frequent severe sharp lower back and tailbone pain with tightness. She complains of difficulty with sleeping, anxiety, fatigue at work, feelings of discrimination, mood changes, crying spells and thoughts of suicide. The medical records also indicate worsening of the activities of daily living. Per the treating physician report dated 7-24-15 the work status is temporary totally disabled but she is currently working. The physical exam dated 7-24-15 reveals tenderness to palpation, with limited painful range of motion and positive orthopedic evaluation of the cervical spine, lumbar spine and upper and lower extremities. There is decreased sensory at C6-7 on the right, decreased right shoulder range of motion, weakness, positive Speeds and positive impingement. There is decreased cervical range of motion, and

positive bilateral shoulder depression. The right wrist has positive Tinel's. The right elbow has positive Mills, positive Cozens, and positive varus. The bilateral knees have positive McMurray test. The lumbar range of motion is decreased with positive bilateral seated root test and bilateral positive heel toe walk. There are no previous treatments noted. The request for authorization date was 8-19-15 and requested services included Chiropractic treatment at 2 times per week for the bilateral elbows, knees, right wrist, cervical spine and right shoulder, Occupational medicine consult, Transcutaneous electrical nerve stimulation (TENS) -EMS unit one month rental, X-rays of the cervical spine, X-ray of the right shoulder, X Ray of the knees, X Ray of the right wrist, X- ray of the elbows, X Ray of the lumbosacral spine, Psych evaluation, and Sleep study. The original Utilization review dated 8-28-15 modified the request for Chiropractic treatment at 2 times per week for the bilateral elbows, knees, right wrist, cervical spine and right shoulder modified to chiropractic treatment times 4 visits for the cervical spine with 2 of those visits to include manipulation of the shoulder and elbow. The request for Occupational medicine consult, Transcutaneous electrical nerve stimulation (TENS) -EMS unit one month rental, X-rays of the cervical spine, X-ray of the right shoulder, X Ray of the knees, X Ray of the right wrist, X- ray of the elbows, X Ray of the lumbosacral spine, Psych evaluation, and Sleep study was non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic treatment at 2 times per week for the bilateral elbows, knees, right wrist, cervical spine and right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines.

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

Decision rationale: CA MTUS chronic pain guidelines for manual therapy and manipulation are used in support of this decision. It is assumed this request is for ongoing chiropractic care for a chronic condition. Documentation does not include the number of previous chiropractic treatments or any measure of functional improvement resulting from these treatments. Other conservative treatments with the exception of medications are not included in the chart materials. The request does not include a specific number of requested visits. Without an incomplete request and potential for indefinite visits, the request for chiropractic care is determined not medically necessary.

Occupational medicine consult: Upheld

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

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

Decision rationale: Ca MTUS is silent on this issue. The above cited guideline states "office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment." It is unclear from the record why the provider was requesting an occupational medicine consult. The submitted documentation does not discuss signs, symptoms, or differential diagnosis to support an occupational medicine consult. There is no documentation of decreased reliance on medication or functional improvement. Documentation does not include return to work goals. There are not clear diagnostic questions presented for this request. Without support of the documentation, the request is determined not medically necessary.

TENS/EMS unit one month rental: Upheld

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

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Initial Care, Physical Methods, Activity.

Decision rationale: The CA MTUS ACOEM guidelines recommend against the use of TENS units for the management of low back complaints. Additionally, the chronic pain management guidelines recommend against this therapy as a primary treatment, but support a one month home based trial. The use of this machine should be part of an overall treatment plan including medication and therapy. The request does not document the body part the TENS unit is intended to treat. Without this documentation and non-adherence to the guidelines, the request for a TENS unit is determined not medically necessary.

X-rays of the cervical spine: Upheld

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

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Physical Examination, Diagnostic Criteria, Special Studies.

Decision rationale: There is no documentation of trauma or injury to the cervical spine. The provider who requested the cervical images documented the absence of neurologic findings - including muscle weakness or neuropathy. The records also document this is the first examination of the cervical spine related to this injury. According to MTUS guidelines, imaging of the cervical spine is not indicated unless symptoms extend beyond 3-4 weeks of conservative care. The exception is for red flag conditions such as evidence of neurologic dysfunction, failure to progress in a strengthening program, or for anatomy clarification. The records do not support any objective findings. Without this supporting documentation, the request for cervical radiography is not medically necessary.

X-ray of the right shoulder: Overturned

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

MAXIMUS guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Physical Examination, Diagnostic Criteria, Initial Care.

Decision rationale: The documentation supports the IW sustained trauma to his right shoulder when he fell into a mounted fire extinguisher. The record does not support the IW has previously had imaging of the injured shoulder. Guidelines state, "Routine testing (laboratory tests, plain-film radiographs of the shoulder) and more specialized imaging studies are not recommended during the first month to six weeks of activity limitation due to shoulder symptoms, except when a red flag noted on history or examination raises suspicion of a serious shoulder condition or referred pain." Guidelines go on to states, "Imaging may be considered for a patient whose limitations due to consistent symptoms have persisted for one month or more." The IW has ongoing pain in the same region as the trauma. Physical exam findings have been consistent across examination. The injury was greater than 1 month ago. As such, the request is determined medically necessary.

X Ray of the knees: Upheld

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

MAXIMUS guideline: Decision based on MTUS Knee Complaints 2004, Section(s): Physical Examination, Diagnostic Criteria.

Decision rationale: The documentation does not support trauma or mechanism for IW new complaint of knee pain. The physical exam documented pain with palpation, but normal motor and sensory examination. The provider did not document the IW's gait pattern. According the referenced guidelines, knee radiographic imaging is not recommended for initial evaluation of non-traumatic knee pain in the absence of red flag conditions. Without out documentation to support these findings, the request for bilateral knee x-rays is not medically necessary.

X Ray of the right wrist: Upheld

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

MAXIMUS guideline: Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004, Section(s): Diagnostic Criteria, Physical Methods, Special Studies.

Decision rationale: The documentation does not support trauma or mechanism for IW's report of right wrist pain. Physical exam did not identify any abnormalities other than pain with palpation. There is no documentation of a detailed neuromuscular examination of this wrist. There were no red flag conditions as outlined by referenced guidelines. Without documentation to support recent trauma or red flag conditions, the request for right wrist x-rays is not medically necessary.

X- ray of the elbows: Upheld

Claims Administrator guideline: Decision based on MTUS Elbow Complaints 2007. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS Elbow Complaints 2007, Section(s): Basic Principles, Diagnostic Criteria.

Decision rationale: The documentation does not support trauma or mechanism for IW's report of bilateral elbow pain. Physical exam does not identify any abnormalities other than pain with palpation. There is no documentation of a detailed neuromuscular examination of the elbows. There were no red flag conditions as outlined by referenced guidelines. Without documentation to support recent trauma or red flag conditions, the request for bilateral elbow pan is not medically necessary.

X Ray of the lumbosacral spine: Upheld

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

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Physical Examination, Diagnosic Criteria, Special Studies.

Decision rationale: Documentation did not support acute trauma or new injury to explain the reported low back pain. Physical exam did not report abnormal findings of the back examination. According to the above referenced guidelines, lumbar imaging is recommended only for IW with red flag conditions. The recommendations further states "In the absence of red flags, imaging and other tests are not usually helpful during the first four to six weeks of low back symptoms." The documentation does not support indications; therefore, request for lumbar x-rays are not medically necessary.

Psych evaluation: Upheld

Claims Administrator guideline: Decision based on MTUS Stress-Related Conditions 2004. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS Stress-Related Conditions 2004, Section(s): Initial Assessment, Medical, Treatment.

Decision rationale: According the above referenced guidelines, "Specialty referral may be necessary when patients have significant psychopathology or serious medical comorbidities. Some mental illnesses are chronic conditions, so establishing a good working relationship with the patient may facilitate a referral or the return-to-work process. Treating specific psychiatric diagnoses are described in other practice guidelines and texts. It is recognized that primary care physicians and other nonpsychological specialists commonly deal with and try to treat psychiatric conditions. It is recommended that serious conditions such as severe depression and schizophrenia be referred to a specialist, while common psychiatric conditions, such as mild depression, are referred to a specialist after symptoms continue for more than six to eight weeks." The documentation does not discuss objective findings of mental illness, only subjective reports of emotional upset. There are no screening mental health questions, aberrant behaviors, or details of mood discussed. There is no diagnosis of a mental health illness. Without the support of the guideline or adherence to the guidelines, the request is determined 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.

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 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.