

Case Number:	CM15-0199531		
Date Assigned:	10/19/2015	Date of Injury:	10/16/2013
Decision Date:	12/23/2015	UR Denial Date:	09/23/2015
Priority:	Standard	Application Received:	10/09/2015

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 40 year old male, who sustained an industrial-work injury on 10-16-13. He reported initial complaints of lower back pain radiating to the feet. The injured worker was diagnosed as having diabetes mellitus, abdominal pain, acid reflux, sleep disorder, inguinal pain-hernia, cervical stenosis, lumbar spine sprain disc protrusion-theal sac stenosis-foraminal narrowing-root nerve compression, left foot strain, and epilepsy. Treatment to date has included medication, physical therapy, acupuncture, diagnostics, lumbar ESI (epidural steroid injections), 3 chiropractic treatments, and diagnostics. Currently, the injured worker complains of headache, cervical spine, thoracic spine, bilateral shoulders, abdomen, and internal system, urology, left inguinal area, lumbar spine, bilateral upper extremities, bilateral lower extremities, bilateral feet, insomnia, and cognitive impairment-stress. Per the primary physician's progress report (PR-2) on 8-27-15, exam noted moderately elevated blood pressure, normal abdomen, extremities tenderness and range of motion exam was deferred. The Request for Authorization requested service to include Cardio respiratory testing, Sudoscan, Urine Toxicology, Labs: AML, LIPS, HGBA1C, CMPR, CBD, LIPR, UMAR, TSH, T3, T4, U/A (urinalysis), ICG Impedance Cardiogram, Testicular Ultrasound, Urology Consult, Body composition study, Theramine Cap #60; 2 bottles, Sentra PM #60, Pelvic Ultrasound, and 2D Echocardiography. The Utilization Review on 9-23-15 denied the request for Cardio respiratory testing, Sudoscan, Urine Toxicology, Labs: AML, LIPS, HGBA1C, CMPR, CBD, LIPR, UMAR, TSH, T3, T4, U/A (urinalysis), ICG Impedance Cardiogram, Testicular Ultrasound, Urology Consult, Body composition study, Theramine Cap #60; 2 bottles, Sentra PM #60, Pelvic Ultrasound, and 2D Echocardiography, per CA MTUS (California Medical Treatment Utilization Schedule),

Chronic Pain Medical Treatment Guidelines 2009 and Harrison's Principles of Internal Medicine, 13th Edition 2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cardio respiratory testing: 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 Clinician's Guide To Cardiopulmonary Exercise Testing in Adults, Circulation. 2010; 122: 191-225 Published online before print June 28, 2010.

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of this test for this patient. The California MTUS guidelines, ACOEM Guidelines and the Occupational Disability Guidelines (ODG) do not address this topic. Therefore outside sources were sought. When combined with exercise testing, adjunctive imaging modalities offer greater diagnostic accuracy, additional information regarding cardiac structure and function, and additional prognostic information. The American Heart Association recommends that Cardiopulmonary exercise testing be performed in adults to assess cardiac output and pulmonary compliance. The reason for this test being ordered is unclear. This patient has not been documented to have any signs of recent unstable angina. This type of test is not performed as a standing screening procedure. Therefore, based on the submitted medical documentation, the request for cardiopulmonary testing is not-medically necessary.

Sudoscan: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment Index, 13th Edition (web) 20155.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Chronic Pain, Sudoscan.

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of a history and physical exam for this patient. Per ODG, Sudoscan is not generally recommended as a diagnostic test for CRP. The medical records support that this patient has chronic back pain which has been stable with no recent flare-ups or acute interventions. The patient's pain appears to be at a steady state for which he has been receiving chiropractic manipulation on a routine basis. Therefore, based on the submitted medical documentation, medical necessity for chiropractic therapy has not been established, not medically necessary.

Urine Toxicology: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Drug testing.

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

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of a toxicology screen for this patient. The clinical records submitted do not support the fact that this patient has been documented to have a positive drug screen for illicit or non-prescribed substances. The MTUS guidelines recommend frequent and random urine drug screens where aberrant behavior is suspected. This patient has not been documented to have suspicion of aberrant behavior. His pain is documented as well controlled and past drug screens are consistent with currently prescribed medications. Therefore, based on the submitted medical documentation, the request for drug toxicology is not-medically necessary.

Labs: AML, LIPS, HGBA1C, CMPR, CBD, LIPR, UMAR, TSH, T3, T4, U/A: Upheld

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

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

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of the requested labs for this patient. The California MTUS guidelines state that: An erythrocyte sedimentation rate (ESR), complete blood count (CBC), and tests for autoimmune diseases (such as rheumatoid factor) can be useful to screen for inflammatory or autoimmune sources of joint pain. All of these tests can be used to confirm clinical impressions, rather than purely as screening tests in a shotgun attempt to clarify reasons for unexplained shoulder complaints. The medical documentation submitted does not clearly indicate that this patient exhibits signs or symptoms of a rheumatological or idiopathic inflammatory condition. Evidence of anemia (macrocytic or otherwise) is not demonstrated on physical exam. Furthermore, the patient is documented to have no concern for acute electrolyte abnormalities or abnormal liver function, which would indicate the necessity for a CMPR test. Therefore, based on the submitted medical documentation, the request for AML, Lipids, HbgA1c, CMPR, LIPR, UMAR, TSH, T3, T4 and U/A testing is not-medically necessary.

ICG Impedance Cardiogram: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Harrison's Principles of Internal Medicine, 13th Edition 2015.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Accuracy of impedance cardiography for evaluating trends in cardiac output. Heinink TP, Lund JN, Williams JP. Br J Anaesth. 2015 Aug; 115(2):322-3.

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of this intervention for this patient. The California MTUS guidelines, the Official Disability Guidelines (ODG) and the ACOEM Guidelines do not address this topic. Therefore, outside sources were sought. Impedance cardiography (ICG) is a noninvasive modality that utilizes changes in impedance across the thorax to assess hemodynamic parameters, including cardiac output (CO). The indication for this test is unclear. The medical records provide no justification for the reason this test was ordered. The patient does not have a history of unstable angina or decompensate congestive heart failure. The test is not a recommended routine screening test. Therefore, based on the submitted medical documentation, medical necessity for impedance cardiography has not been established, therefore is not medically necessary.

Testicular Ultrasound: 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 American College of Radiology (ACR), Practice Guideline for the Performance of Scrotal Ultrasound Examinations.

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of this request for this patient. The California MTUS guidelines do not address this topic. As noted by the American College of Radiology (ACR), indications for a scrotal ultrasound include evaluation of scrotal pain, evaluation of possible varicoceles, evaluation of scrotal masses, and/or evaluation of testicular trauma or other scrotal disease, and/or evaluation of an occult testicular tumor. In this case, the applicant has persistent scrotal and testicular pain issues. A clear potential etiology for the patient's pain has not been established or documented. Pain is scored subjectively and has not been associated with any urologic or genital dysfunction. Therefore, based on the submitted medical documentation, the request for a testicular ultrasound is not medically necessary.

Urology Consult: Upheld

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

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 a urology consultation for this patient. The clinical records submitted do not support the fact that this patient has been documented to have recent urological disease requiring consultation. The California MTUS guidelines address the issue of consultants by stating: If

physiologic evidence indicates tissue insult or nerve impairment, consider a discussion with a consultant regarding next steps. This patient has not been documented to have any recent evidence of urologic dysfunction, including tissue insult or nerve impairment. Therefore, based on the submitted medical documentation, the request for Urology consultation is not-medically necessary.

Body composition study: 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 Obesity Education Initiative: Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults, National Institutes of Health, National Heart, Lung, and Blood Institute, Obesity Research 1998, 6 Suppl 2:51S-209S, Updated for the American Heart Association, 2015.

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of this intervention for this patient. The California MTUS guidelines, the Official Disability Guidelines (ODG) and the ACOEM Guidelines do not address this topic. Therefore, outside sources were sought. According to the American Heart Association, body composition testing can include a multitude of tests. Waist circumference and body mass index (BMI) are indirect ways to assess your body composition. Waist-to-hip ratio (WHR) is another index of body fat distribution. However, WHR is less accurate than BMI or waist circumference and is no longer recommended. The indication for this test is unclear. The medical records provide no justification for the reason this test was ordered. The test is not a recommended routine screening test. Therefore, based on the submitted medical documentation, medical necessity for body composition testing has not been established, therefore is not medically necessary.

Theramine Cap #60; 2 bottles: 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, medical foods; Theramine.

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of this medication for this patient. The California MTUS guidelines and the ACOEM Guidelines do not address this topic. According to the Official Disability Guidelines (ODG), Theramine is: Not recommended for the treatment of chronic pain. Theramine is a medical food that contains 5-hydroxytryptophan 95%, choline bitartrate, L-arginine, histidine, L-glutamine, L-serine, gamma-aminobutyric acid (GABA), whey protein concentrates, grape seed extract 85%, cinnamon, and cocoa (theobromine 6%). This patient has chronic lower back pain secondary to an industrial accident. Per ODG, teramine is specifically not indicated for the treatment of chronic pain. Therefore, based on the submitted medical documentation, the request for Theramine is not medically necessary.

Sentra PM #60: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain, Sentra AM/PM.

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of this request for this patient. The Official Disability Guidelines state that Sentra PM is not recommended. Sentra PM is a medical food [REDACTED], intended for use in management of sleep disorders associated with depression. It is a proprietary blend of choline bitartrate, glutamate, and 5-hydroxytryptophan, hawthorn berry, cocoa, ginkgo biloba, and acetyl L-carnitine. There was no rationale submitted in the submitted documentation to indicate the use of Sentra PM other than the patient's chronic pain syndrome. There were no other significant factors provided to justify the use outside of the current guidelines. Given the evidence based guidelines and the lack of submitted documentation, the request would not be indicated. Therefore, based on the submitted medical documentation, the request for Sentra PM is not-medically necessary.

Pelvic Ultrasound: 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) Hip and Pelvis, Ultrasound (Sonography).

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of this request for this patient. MTUS reference to ACOEM Guidelines identifies that ultrasound has no proven efficacy in treating acute low back symptoms and insufficient scientific testing exists to determine the effectiveness of ultrasound (therapeutic). ODG identifies documentation of scar tissue, adhesions, collagen fiber and muscle spasm, or the need to extend muscle tissue or accelerate the soft tissue healing, as criteria necessary to support the medical necessity of diagnostic ultrasound for hip/pelvis. Medical Treatment Guideline identifies documentation of a condition/diagnosis (with supportive subjective/objective findings) for which a pelvic ultrasound is indicated (such as: Evaluation of pelvic pain; Evaluation of pelvic masses; Evaluation of endocrine abnormalities, including polycystic ovaries; Evaluation of dysmenorrhea (painful menses); Evaluation of amenorrhea; Evaluation of abnormal vaginal bleeding). The medical records submitted for review do indicate that this patient has had persistent back pain. Documentation of pelvic disease is not found in the medical records. Other than chronic pain, the reason for the requested ultrasound is unclear. Therefore, based on the submitted medical documentation, the request for a pelvic ultrasound is not medically necessary.

2D Echocardiography: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Harrison's Principles of Internal Medicine, 13th Edition 2015.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Antman EM, Smith SC, Alpert JS, et al. ACC/AHA/ASE 2003 Guideline Update for the Clinical Application of Echocardiography. ACC/AHA Practice Guidelines. Dallas, TX: American Heart Association; 2003. Available at: <http://www.americanheart.org/>. Gottdiener JS, Bednarz J, Devereix R, et al. American Society of Echocardiography recommendations for use of echocardiography in clinical trials. A report from the American Society of Echocardiography's Guidelines and Standards Committee and the Task Force on Echocardiography in Clinical Trials. American Society of Echocardiography Report. J Am Soc Echocardiography. 2004; 17(10):1086-1119.

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of testing for this patient. The California MTUS guidelines, ACOEM Guidelines and the Occupational Disability Guidelines (ODG) do not address this topic. Echocardiography is an ultrasound technique for diagnosing cardiovascular disorders. Evidence-based guidelines from the American College of Cardiology, American Heart Association, and American Society of Echocardiography outlined the accepted capabilities for Doppler echocardiography in the adult patient. Among indications related to anatomy-pathology, color Doppler was rated as most helpful for evaluating septal defects. Among functional indications, color Doppler was considered most useful for evaluating the site of right-to-left and left-to-right shunts (Antman et al, 2003). Color Doppler was also considered useful for evaluating severity of valve stenosis and valve regurgitation and evaluation of prosthetic valves. This patient has no indication for an echocardiogram with any new complaints of unstable angina or valvular disease. In this clinical situation, a test is not warranted. Therefore, based on the submitted medical documentation, the request for 2D echocardiogram is not-medically necessary.