

<b>Case Number:</b>	CM15-0026982		
<b>Date Assigned:</b>	02/19/2015	<b>Date of Injury:</b>	08/20/2012
<b>Decision Date:</b>	04/16/2015	<b>UR Denial Date:</b>	02/02/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/12/2015

### 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: Pennsylvania  
 Certification(s)/Specialty: Internal 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 54 year old male who sustained an industrial injury on August 20, 2012. He reported low back pain, bilateral knee pain, stress and anxiety. The injured worker was diagnosed as having lumbar spine disc disease, left leg sciatica, lumbar spine spondylosis, knee osteoarthritis/degenerative joint disease, knee medial meniscus tear, weight gain, hypertension, depression, acid reflux, and sexual dysfunction secondary to back injury. Treatment/evaluation to date has included radiographic imaging, electrodiagnostic studies, left knee surgery, physical therapy, medications, psychological evaluations and work restrictions. The documentation submitted notes sleep issues with insomnia secondary to pain, gastroesophageal reflux treated with various medications, and sexual dysfunction. Work status was noted as temporarily totally disabled and later stated as permanent and stationary. An Agreed Medical Evaluation (AME) on 7/21/14 noted a diagnosis of hypertension, and that the injured worker had frequent episodes of shortness of breath, chest pain/pressure/tightness which the injured worker attributed to anxiety. Physical examination included an ophthalmologic examination that showed no conjunctival injection, pupils equally round and reactive to light, extraocular movements intact, direct undilated ophthalmoscopic exam was without abnormalities of the arterioles, veins, or discs, and with no hemorrhages or exudates. Cardiac examination showed regular rate and rhythm, and examination of the abdomen showed it to be soft, nontender, no masses, no rebound, no guarding, and bowel sounds present in four quadrants. Laboratory studies on that date were noted to show dyslipidemia and mild elevation of the C-reactive protein, slight elevation of glucose, stool for occult blood negative, H. pylori serology negative. Electrocardiogram showed sinus

tachycardia, one premature ventricular contraction, and Q waves in the inferior leads suggestive of possible prior infarct, with no changes of acute ischemia. Echocardiogram showed normal wall motion and ejection fraction, and stress test showed submaximal heart rate response with post-exercise echocardiogram with no regional wall motion abnormalities of ischemia. A diagnostic impression of chest pain/shortness of breath not due to cardiac ischemia was documented. Evaluation on July 29, 2014, revealed continued pain. A neurosurgical spine consultation, pain management consultation and psychiatric evaluation were discussed. Physical therapy to the lumbar spine was recommended as well as weight management. Evaluation by the primary treating physician on August 26, 2014, revealed continued low back and knee pain; the injured worker reported erectile dysfunction. Examination revealed the injured worker required use of a cane and was wearing a back brace. There was tenderness over the medial and lateral joint line of the right knee and decreased strength in the lower extremities. The treating physician documented referral to urology for consultation to address erectile dysfunction. On 11/5/14, a secondary treating physician/internal medicine consultant documented controlled hypertension, constipation and diarrhea, snoring and shortness of breath at night, with diagnoses of acid reflux secondary to stress/rule out ulcer/anatomical alteration, and sleep disturbance/rule out obstructive sleep apnea. Medications included dexilant and Benicar. The physician documented he was unable to visualize the fundus on eye examination, abdomen showed one plus epigastric tenderness, heart exam showed regular rate and rhythm with no rubs or gallops appreciated, and examination of the extremities showed discoloration of bilateral feet with cold extremities noted. Endoscopy/colonoscopy, cardiology consultation, dermatology consultation secondary to diabetic dermopathy, ophthalmology consultation to rule out end-organ damage secondary to hypertension, urology consultation, and sleep study referral were recommended. On 2/25/15, Utilization Review non-certified requests for sleep study, urology consult, cardiology consult, ophthalmology consult, dermatology consult, and EGD/colonoscopy. Utilization Review cited the MTUS/ACOEM chapter 2 General Approach to Initial Assessment and Documentation, and noted that the lack of full clinical data supports non-authorization of the requested services.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Sleep Study:** 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 Official Disability Guidelines (ODG) pain chapter: polysomnography.

**Decision rationale:** The MTUS does not provide direction for evaluating or treating sleep disorders. The ODG states that polysomnography is recommended after at least six months of an insomnia complaint (at least four nights a week) unresponsive to behavior intervention and medications and after a psychiatric etiology has been excluded. Polysomnography is also indicated when a sleep related breathing disorder or periodic limb movement disorder is suspected. The ODG lists additional criteria for polysomnography and states that home sleep

studies are an option. A sleep study for the sole complaint of snoring is not recommended. The criteria per the ODG for sleep studies include a combination of indications including excessive daytime somnolence, cataplexy, morning headaches, intellectual deterioration, personality change, suspicion of sleep-related breathing disorder or periodic limb movement disorder, and insomnia complaint for at least six months. The injured worker was noted to have insomnia secondary to pain and snoring and shortness of breath at night, but no other indications for the test as noted above. The reason for the sleep study was noted as sleep disturbance/rule out obstructive sleep apnea. A detailed history/evaluation of sleep disorder was not documented. Due to insufficient indication, the request for sleep study is not medically necessary.

**Urology Consult:** Overturned

**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 Official Disability Guidelines (ODG) low back chapter: office visits and Other Medical Treatment Guidelines Cunningham, Glenn et al. Evaluation of male sexual dysfunction. In UpToDate, edited by Ted. W. Post, published by UpToDate in Waltham, MA, 2015.

**Decision rationale:** The ODG notes that office visits are recommended as determined to be medically necessary. The need for a clinical 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. The injured worker was noted to have sexual dysfunction secondary to back injury. The primary treating physician, an orthopedic surgeon, requested urology referral for consultation to address erectile dysfunction, noting that this was outside his area of expertise. The evaluation of erectile dysfunction should include pertinent history, physical examination, assessment of secondary sexual characteristics, vascular examination, hormonal testing, and in some cases additional diagnostic testing. Such evaluation is commonly performed by a specialist in urology. As such, the request for urology consultation is medically necessary.

**Cardiology Consult:** 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 Official Disability Guidelines (ODG) low back chapter: office visits and Other Medical Treatment Guidelines Meisel, James. Diagnostic approach to chest pain in adults. In UpToDate, edited by Ted. W. Post, published by UpToDate in Waltham, MA, 2015.

**Decision rationale:** The ODG notes that office visits are recommended as determined to be medically necessary. The need for a clinical 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. The injured worker had a diagnosis of hypertension, noted to be controlled and reported chest pain/pressure/tightness which he attributed to anxiety. In July 2014, an agreed medical evaluator performed an electrocardiogram, stress test, and echocardiogram, after which an impression of chest pain and shortness of breath not due to cardiac ischemia was documented. Subsequent cardiac physical examination findings were documented and were unremarkable. In November 2014, a secondary treating physician in internal medicine noted a request for cardiology consultation, without notation of the reason for the consultation. Algorithm for diagnostic approach chest pain includes the testing already performed for this injured worker. There was no documentation of ongoing symptoms of chest pain or other symptoms suggestive of a cardiac etiology. Due to lack of sufficient indication, the request for cardiology consultation is not medically necessary.

#### **Dermatology Consult:** 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 Official Disability Guidelines (ODG) low back chapter: office visits.

**Decision rationale:** The ODG notes that office visits are recommended as determined to be medically necessary. The need for a clinical 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, the secondary treating physician requested a dermatology consultation for diabetic dermopathy. There was no documentation of diabetes for this injured worker. Physical examination findings related to the skin were noted as discoloration of bilateral feet on the examination of the extremities on 11/5/14. No other dermatologic findings were described. Due to lack of sufficient indication, the request for dermatology consultation is not medically necessary.

#### **Ophthalmology Consult:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 16 Eye Chapter Page(s): 416-417. Decision based on Non-MTUS Citation Kaplan, Norman. Ocular effects of hypertension. In UpToDate, edited by Ted. W. Post, published by UpToDate in Waltham, MA, 2015.

**Decision rationale:** The secondary treating physician requested ophthalmology consult to rule out end-organ damage secondary to hypertension. This physician documented an inability to visualize the fundus on eye examination of 11/5/14. A detailed ocular examination on 7/21/14 noted no abnormalities of the arterioles, veins, or discs, with no hemorrhages or exudates. There were no complaints of ocular irritation, pain or blurry vision. The injured worker had a

longstanding diagnosis of hypertension which was described as controlled with medication. Multiple blood pressure readings were present in the documentation submitted and ranged from 118/81 to 130/94. The ACOEM states that initial assessment should focus on detecting indications of potentially serious ocular pathology which would indicate that further consultation, support, or specialized treatment may be necessary. The additional citation states that funduscopy should be part of the physical examination on every patient with newly diagnosed hypertension. The presence of hypertensive retinopathy should serve as an additional stimulus to ensure adequate control of hypertension. In this case, the diagnosis of hypertension was not new, and blood pressure was controlled with medication. No ocular symptoms or complaints were documented. Examination of the fundus on 7/21/14 showed no evidence of hypertensive retinopathy. Due to lack of specific indication, the request for ophthalmology consultation is not medically necessary.

**EGD/Colonoscopy: 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 Kahrilas, Peter. Medical management of gastroesophageal reflux disease in adults. In UpToDate, edited by Ted. W. Post, published by UpToDate in Waltham, MA, 2015. Lee, Linda et al. Overview of colonoscopy in adults. In UpToDate, edited by Ted. W. Post, published by UpToDate in Waltham, MA, 2015.

**Decision rationale:** The injured worker was noted to have acid reflux which had been treated with various acid-reducing medications for at least several months, most recently dexilant. No use of nonsteroidal anti-inflammatory agents (NSAIDS) was discussed. Diagnostic evaluation in July 2014 showed that the stool was negative for occult blood and testing for H. pylori was negative. In November 2014, complaints of constipation and diarrhea were noted, and examination of the abdomen showed epigastric tenderness. A diagnosis of acid reflux secondary to stress/rule out ulcer/anatomical alteration was noted. Indications for upper endoscopy in patients with gastroesophageal reflux disease include heartburn with alarm features such as dysphagia, odynophagia, gastrointestinal bleeding, anemia, weight loss, and recurrent vomiting; men older than 50 years with chronic gastroesophageal reflux symptoms for more than five years and additional risk factors for Barrett's esophagus and esophageal adenocarcinoma, and patients with reflux symptoms that persist despite a therapeutic trial of four to eight weeks of twice daily proton pump inhibitor therapy. None of these indications for upper endoscopy were present in this injured worker. Diagnostic indications for colonoscopy include screening or surveillance for colon cancer, evaluating signs and symptoms suggestive of possible colonic or distal small bowel disease including lower gastrointestinal bleeding and chronic clinically significant diarrhea without an explanation, assessing a response to treatment in patients with known colonic disease (eg, inflammatory bowel disease), and evaluating abnormalities found on imaging studies. None of these indications for colonoscopy were present in this injured worker. Due to lack of sufficient indication, the request for EGD/colonoscopy is not medically necessary.