MAXIMUS Federal Services

Case Number:	CM14-0097320		
Date Assigned:	08/08/2014	Date of Injury:	09/09/1985
Decision Date:	10/06/2014	UR Denial Date:	06/14/2014
Priority:	Standard	Application Received:	06/25/2014

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. The expert reviewer is Board Certified in Occupational Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 applicant is a represented [redacted] employee who has filed a claim for chronic low back pain reportedly associated with an industrial injury of September 9, 1985. Thus far, the applicant has been treated with the following: Analgesic medications; attorney representation; transfer of care to and from various providers in various specialties; topical applications of heat and cold; unspecified amounts of acupuncture; unspecified amounts of physical therapy over the life of the claim; functional capacity testing; and an ergonomic evaluation. In a utilization review report dated June 14, 2014, the claims administrator denied a request for an Ortho-Stim 4 device, denied a request for three sessions of chiropractic manipulative therapy, denied a lumbar MRI, denied electrodiagnostic testing of bilateral upper extremities, denied electrodiagnostic testing of bilateral lower extremities, denied a psychiatric consultation, denied a sleep medicine consultation, approved an internal medicine consultation, denied a dermatology consultation, denied a rheumatology consultation, denied a Thera-band, and denied a Swiss ball. The claims administrator based its denial, on large part, on a primary treating provider report dated May 15, 2014. The applicant's attorney subsequently appealed. In an earlier note dated August 29, 2012, the applicant was described as having multifocal pain complaint associated with fibromyalgia, including low back pain, wrist pain, and hip pain. The applicant was placed off of work, on total temporary disability, at that point in time. On June 20, 2012, the applicant remained off of work on total temporary disability. On December 11, 2013, the applicant reported worsening of symptoms. The applicant reported heightened neck, back, bilateral wrist, and bilateral hand pain. The applicant was placed off of work owing to severe pain complaints, while Norflex, Medrox, Norco, BuTrans, and Naprosyn were endorsed. In a mental health note dated October 22, 2013, the applicant was given a whole person impairment rating at 23%, based on a global assessment functioning (GAF) score of 55. On January 8, 2014, the applicant was placed off of work owing

to a flare of symptoms, but was reportedly returned to work effective January 10, 2014. The file was surveyed on several occasions. It did not appear that the May 15, 2014, progress note/request for authorization, which was furnished to the claims administrator, was incorporated into the independent medical review packet. In a January 8, 2014 progress note, the applicant's former treating provider posited that the applicant was having issues with sleep disturbance and had not seen a psychiatrist recently.

IMR ISSUES, DECISIONS AND RATIONALES

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

Orthostim 4 Unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Orthostim 4 Unit:.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Galvanic Stimulation; Neuromuscular Electrical Stimulation Page(s): 117; 111. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: http://www.vqorthocare.com/products/orthostim-4-surgistim-4/

Decision rationale: The request for an Ortho-Stim 4 unit is not medically necessary, medically appropriate, or indicated here. A survey of the product description suggests that the OrthoStim contains a variety of modalities, which carries unfavorable recommendations in the MTUS Chronic Pain Medical Treatment Guidelines. The OrthoStim includes high voltage current stimulation and neuromuscular electrical stimulation. However, as noted on page 121 of the MTUS Chronic Pain Medical Treatment Guidelines, neuromuscular stimulation is not recommended outside of the post-stroke rehabilitative context and is not recommended in the chronic pain context present here. Similarly, galvanic stimulation/high voltage stimulation, another modality which compromises the device, is likewise "not recommended," per page 117 of the MTUS Chronic Pain Medical Treatment Guidelines. Since multiple modalities which compromise the device are not recommended, the entire device is not recommended. Therefore, the request is not medically necessary.

MRI(Magnetic Resonance Imaging) of the Lumbar Spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 304.

Decision rationale: The proposed lumbar MRI is likewise not medically necessary, medically appropriate, or indicated here. As noted in the MTUS-adopted ACOEM Guidelines in Chapter 12, page 304, imaging studies of the lumbar spine are not recommended except in cases in which surgical intervention is being considered or red flag diagnoses are being evaluated. In this case, however, there is no evidence that the applicant is actively considering or contemplating any

kind of surgical intervention insofar as the lumbar spine is concerned. Although it is acknowledged that the May 15, 2014 progress note on which this and other requests were initiated was not incorporated into the independent medical review packet. Based on the information on file, then the request is not medically necessary.

EMG(Electromyography) of the Bilateral Upper Extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178. Decision based on Non-MTUS Citation Official Disability Guidelines- Neck and Upper back chapter

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): TABLE 8-8, PAGE 182.

Decision rationale: Similarly, the request for electrodiagnostic testing of the bilateral upper extremities is not medically necessary, medically appropriate, or indicated here. While the MTUS Guideline in ACOEM Chapter 8, Table 8-8, page 182 does acknowledge that EMG testing to clarity diagnosis of nerve root dysfunction is "recommended" is case of suspected disc herniation preoperatively or before epidural steroid injection therapy, in this case, however, it appears that the applicant carries a diagnosis of multifocal pain syndrome secondary to fibromyalgia, at least based on the reports of the applicant's former primary treating provider (PTP). EMG testing would be of no use in establishing the diagnosis of chronic pain secondary to fibromyalgia. It is acknowledged, as with the other request, that it appears that the claims administrator failed to incorporate the May 15, 2014 progress note, on which this and other requests were initiated into the independent medical review packet. Based on the information, which is on file, thus, the request is not medically necessary.

NCV(Nerve Conduction Velocity Test) of the Bilateral Upper Extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178. Decision based on Non-MTUS Citation Official Disability Guidelines- Neck and Upper back chapter

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): TABLE 11-7, PAGE 272.

Decision rationale: The request for nerve conduction testing of the bilateral upper extremities is likewise not medically necessary, medically appropriate, or indicated here. While the MTUS Guideline in ACOEM Chapter 11, Table 11-7, page 272 does recommend nerve conduction testing for median and ulnar nerve impingement at the wrist after failure of conservative treatment, in this case, the information on file points to the applicant carrying a diagnosis of multifocal pain syndrome secondary to fibromyalgia as opposed to any focal median or ulnar entrapment neuropathy, although it is acknowledged that the claims administrator has seemingly failed to incorporate the May 15, 2014 progress note on which this and other articles were requested into the independent medical review packet. The request, thus, cannot be supported

based on the information, which is currently on file. Therefore, the request is not medically necessary.

NCV(Nerve Conduction Velocity Test) of the Bilateral Lower Extremities: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines- Low Back-Lumbar & Thoracic (Acute & Chronic)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints Page(s): TABLE 14-6, PAGE 377.

Decision rationale: Similarly, the request for nerve conduction testing of the bilateral lower extremities is likewise not medically necessary, medically appropriate or indicated here. As noted in the MTUS-adopted ACOEM Guidelines in Chapter 14, Table 14-6, page 377, Electrical Studies for routine foot and ankle problems without clinical evidence of tarsal tunnel syndrome or other entrapment neuropathies is "not recommended." In this case, all evidence on file points to the applicant carrying a diagnosis of multifocal pain syndrome secondary to fibromyalgia. There was no evidence or suggestion of any lower extremity entrapment neuropathy or generalized peripheral neuropathy, which would compel nerve conduction testing of the bilateral lower extremities, although as with the other request, it is acknowledged that the claims administrator had seemingly failed to incorporate a May 15, 2014 progress note on which this and other articles were requested into the independent medical review packet. Therefore, the request is not medically necessary.

EMG(Electromyography) of the Bilateral Lower Extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309.

Decision rationale: While the MTUS Guideline in ACOEM Chapter 12, Table 12-8, page 309 does acknowledge that EMG testing is "recommended" to clarify a diagnosis of suspected nerve root dysfunction is, in this case, however, it appears that the applicant carries a diagnosis of multifocal pain syndrome secondary to fibromyalgia, at least based on the reports of the applicant's former primary treating provider (PTP). EMG testing would be of no use in establishing a diagnosis of chronic lower extremity pain secondary to fibromyalgia. It is acknowledged, as with the other requests, that it appears that the claims administrator failed to incorporate the May 15, 2014 progress note, on which this and other requests were initiated into the independent medical review packet. Based on the information which is presently on file, however, the request is not medically necessary.

Diagnostic Ultrasound of the right knee: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee and leg (Acute & Chronic)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: ACOEM V.3 > Knee > Diagnostic Testing > Ultrasound Recommendation: Ultrasound for Evaluating Patellar Tendinopathy, Pes Anserine Bursitis, Hamstring Strains, Quadriceps Strains, or Post-arthroplasty Chronic Pain When Peri-Articular Masses Are Suspected Ultrasound is recommended for evaluating patients with patellar tendinopathy, pes anserine bursitis, hamstring strains, quadriceps strains

Decision rationale: The request for diagnostic ultrasound testing of the right knee is likewise not medically necessary, medically appropriate, or indicated here. The MTUS does not address the topic. While the Third Edition ACOEM Guidelines do recommend ultrasound imaging of the knee to evaluate applicants with patellar tendinopathy, pes anserine bursitis, hamstring strains, quadriceps strains, or post arthroplasty chronic pain, when periarticular masses are suspected, in this case, however, it was not stated what was sought. No rationale for pursuit of the knee ultrasound study in question was on file, although it is acknowledged that claims administrator had seemingly failed to incorporate the May 15, 2014 progress note on which this and other articles were requested. The available information on file, however, does not substantiate or support the request. Therefore, the request is not medically necessary.

Psychiatry Consultation: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 398.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 388.

Decision rationale: The request for psychiatric consultation, conversely, is medically necessary, medically appropriate, and indicated here. As noted in the MTUS-adopted ACOEM Guidelines in Chapter 15, page 388, referral to a mental health professional is indicated in applicants whose symptoms become disabling despite primary care intervention or persists beyond three months. In this case, the documentation of the applicant's former treating provider, while admittedly incomplete, did seemingly suggested that the applicant was having mental stress-induced issues with sleep disturbance. Obtaining the added expertise of a psychiatrist to further evaluate the same is indicated. Therefore, the request is medically necessary.

Sleep Medicine Specialist Consultation: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical

Evidence: Citation: Schutte-Rodin S; Broch L; Buysse D; Dorsey C; Sateia M. Clinical guideline for the evaluation and management of chronic in- somnia in adults. J Clin Sleep Med 2008;4(5):487-504. . Polysomnography and daytime multiple sleep latency test- ing (MSLT) are not indicated in the routine evaluation of chronic insomnia, including insomnia due to psychiatric or neuropsychiatric disorders. (Standard)

Decision rationale: The request for a sleep medicine specialist consultation, conversely, is not medically necessary, medically appropriate, or indicated here. The MTUS does not address the topic. As noted by the American Academy of Sleep Medicine (AASM), however, polysomnography, and by implication, evaluation with a sleep specialist is "not indicated" in the routine evaluation of chronic insomnia, including insomnia due to psychiatric or neuropsychiatric disorders. In this case, the admittedly limited information on file points to the applicant having issues with mental stress-induced insomnia as opposed to insomnia due to a bona fide sleep disorder. A Sleep Medicine specialist consultation would be of little or no benefit in establishing the presence of insomnia due to psychiatric condition. Therefore, the request is not medically necessary.

Dermatology Consultation: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 92.

Decision rationale: The request for a Dermatology consultation is not medically necessary, medically appropriate, or indicated here. While the MTUS Guideline in ACOEM Chapter 5, page 92, does acknowledge that referral may be appropriate if a practitioner is uncomfortable with treating a particular cause of delayed recovery, in this case, however, it has not been established for what purpose or what diagnosis the dermatology consultation is being sought here, although, as with the many other requests, it is acknowledged that the claims administrator has seemingly failed to incorporate the May 15, 2014 progress note on which this and other requests were made into the independent medical review packet. The information which is on file, however, does not support the request. Therefore, the request is not medically necessary.

Rheumatology Consultation: Overturned

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 92.

Decision rationale: 11. The proposed rheumatology consultation, conversely, is medically necessary, medically appropriate, and indicated here.As noted in the MTUS-adopted ACOEM Guidelines in Chapter 5, page 92, referral may be appropriate when a practitioner is

uncomfortable with treating a particular cause of delayed recovery. In this case, the applicant's former primary treating provider did speculate that the applicant's multifocal pain complaints were the result of fibromyalgia. Fibromyalgia is a diagnosis, which could benefit from the added expertise of a rheumatologist. Therefore, the request is medically necessary.

Thera-Band: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 83.

Decision rationale: The request for a Thera-Band, conversely, is likewise not medically necessary, medically appropriate, or indicated here. The Thera-Band represents a form of resistance band intended to facilitate home exercises. However, as noted in the MTUS-adopted ACOEM Guidelines in Chapter 5, page 83, to achieve functional recovery, applicants must assume certain responsibilities, one of which include adhering to and maintaining exercise regimens. The Thera-Band device at issue, thus, is, per ACOEM, an article of applicant responsibility as opposed to an article of payor responsibility. Accordingly, the request is not medically necessary.

Swiss Ball: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 83.

Decision rationale: The proposed Swiss ball, another device intended to facilitate home exercise, is likewise not medically necessary, medically appropriate, or indicated here. As noted in the MTUS Guideline in ACOEM Chapter 5, page 83, to achieve functional recovery, applicants must assume certain responsibilities, one of which includes adhering to and maintaining exercise regimens. The Swiss ball at issue, thus, is, per ACOEM, an article of applicant responsibility as opposed to an article of payor responsibility. No rationale for selection of this particular device in the face of the ACOEM's unfavorable position on the same was proffered by the attending provider, although as with several other requests it is acknowledged that the claim administrator had seemingly failed to incorporate the May 15, 2014 progress note on which this and other articles were requested into the independent medical review packet. The information which is on file, however, does not support or substantiate the request. Therefore, the request is not medically necessary.