

Case Number:	CM15-0145004		
Date Assigned:	08/06/2015	Date of Injury:	09/14/2012
Decision Date:	11/19/2015	UR Denial Date:	06/23/2015
Priority:	Standard	Application Received:	07/27/2015

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
 Certification(s)/Specialty: Pediatrics, 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:

This is a 69 year old female with a date of injury on 09-14-2012. A review of the medical records indicates that the injured worker is undergoing treatment for abdominal pain, acid reflux, sleep quality and musculoskeletal complaints. Treatment to date consisted of diagnostic studies, prescribed medications, heating pad, right knee brace, modified duties, physical therapy, and periodic follow up visits. Per the treating physician report dated 05-18-2015, the injured worker reported continued pain in the lumbar spine, right knee, right ankle, sleeping difficulties, depression, anxiety, stress, acid reflux, abdominal pain, nausea and constipation. Spine and range of motion exams were deferred to appropriate specialist. Ultrasound of pelvis exam dated 06-23-2015 revealed atrophic uterus with no abnormal adnexal masses or fluid collections. Ultrasound abdomen dated 06-23-2015 revealed normal findings. The current diagnoses included abdominal pain, acid reflux, sleep disorder, orthopedic diagnosis (referred), and psychiatric diagnosis (referred). The treatment plan consisted of diagnostic studies and medication management due to the musculoskeletal complaints and possibility of gastropathy and irritable bowel syndrome secondary to NSAIDs. The treating physician prescribed services for ultrasound of abdomen and pelvis, MRI of lumbar spine and bilateral knees, and x-ray of pelvis, bilateral knees and bilateral hips, now under review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ultrasound of Abdomen QTY 1: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation www.ncbi.nlm.nih.gov/pubmed/8652992, Abdominal ultrasound as a screening method.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation uptodate.com - Diagnostic approach to abdominal pain in adults.

Decision rationale: MTUS and ODG guidelines are silent on ultrasound of the abdomen. Uptodate notes that "chronic abdominal pain is a common complaint, and the vast majority of patients will have a functional disorder, most commonly the irritable bowel syndrome. Initial workup is therefore focused on differentiating benign functional illness from organic pathology. The history should determine the overall time course of the illness, and it should differentiate pain that is fairly constant from pain that is chronic and intermittent. Features that suggest organic illness include unstable vital signs, weight loss, fever, dehydration, electrolyte abnormalities, symptoms or signs of gastrointestinal blood loss, anemia, or signs of malnutrition. The bowel habit is an important part of the history for chronic abdominal pain. While many organic lesions can result in chronic diarrhea, irritable bowel syndrome often presents with swings between diarrhea and constipation, a pattern that is much less likely with organic disease. The clinician must be alert to the common patterns of presentation in functional abdominal pain. Patients often describe their pain in unusual and dramatic fashion, and they may describe very longstanding pain as having particular urgency at the time of the physician encounter. Unrealistic expectations are common, and patients may demand immediate relief from a problem that has bothered them for years. Physical examination must be complete, since many multisystem illnesses could contribute to a nonspecific abdominal complaint. Specifically, the physical examination should clarify any focus of abdominal tenderness that may merit and focus further investigation. Weight should be followed over time, and evidence of dehydration (such as orthostatic changes in vital signs) should be sought. Initial diagnostic testing including the following laboratory measurements should be performed complete blood count with differential, electrolytes, BUN, creatinine, and glucose, calcium, aminotransferases, alkaline phosphatase, and bilirubin, lipase, ferritin, and anti-tissue transglutaminase. Subsequent diagnostic testing at the conclusion of the initial workup, young patients with no evidence of organic disease can be treated symptomatically. The use of further invasive testing should be directed at ruling in or out specific diseases and not as a general screen." A diagnosis of new-onset functional illness should be made only with great caution in patients over 50 years of age. These patients, by virtue of their increased risk of malignancy, will likely require abdominal imaging with ultrasound or CT and upper gastrointestinal tract endoscopy and/or colonoscopy as their symptoms and signs dictate. The history and physical note that symptoms were related to medication and that there was no weight loss over time nor tenderness on examination. The guidelines indicate that laboratory evaluation prior to imaging is warranted and that given the IW's age imaging should be CT scan or direct visualization with endoscopy. The request is not medically necessary and appropriate.

Ultrasound Pelvis QTY 1: 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), Hip & Pelvis (updated 10/9/14), Online Version, ultrasound (sonography).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation uptodate.com - Diagnostic approach to abdominal pain in adults & Evaluation of chronic pelvic pain in women.

Decision rationale: MTUS and ODG guidelines are silent on ultrasound of the abdomen. Uptodate notes that " chronic pelvic pain (CPP) refers to pain of at least six months' duration that occurs below the umbilicus and is severe enough to cause functional disability or require treatment. The International Pelvic Pain Society has developed a detailed history and physical examination form for evaluation of women with CPP. This document includes an extensive review of systems for the reproductive, urological, and gastrointestinal systems; screening questionnaires for sexual and physical abuse, and somatization; and pelvic pain quantification and pain mapping. A complete history of the patient's pain, as well as a thorough review of systems with emphasis on symptoms of urinary tract disease, bowel disease, reproductive tract disease, musculoskeletal disorders, and psychoneurological disorders is essential. Any history of prior treatments; substance dependence; sexual, physical, or psychological abuse; and domestic violence should also be sought. Physical examination can be painful in these patients, thus it is important to proceed gently and with patience. The examination of the abdomen should focus upon identifying areas of localized or generalized tenderness, surgical scars, hernias, and the presence of masses. The pelvic examination should include a careful evaluation of the shape, size, and mobility of the pelvic organs, as well as any areas of tenderness. The history, physical examination, and psychological assessment are the most important components of the diagnostic evaluation (see above). They are complemented by findings from laboratory tests, imaging, and surgical evaluation, when indicated. Laboratory testing is of limited value in evaluating women with CPP. Based upon the clinical findings, baseline tests may be obtained to screen for a chronic infectious or inflammatory process, and to exclude pregnancy. Pelvic ultrasound is highly sensitive for identifying pelvic masses/cysts and determining the origin of the mass. It is less reliable for distinguishing between benign and malignant neoplasms and diagnosing adenomyosis. Sonography is particularly useful for detecting small pelvic masses (less than 4 cm in diameter), which often cannot be palpated on bimanual examination. It is also very useful for detecting hydrosalpinges, which point to pelvic inflammatory disease as the cause of CPP." The history and physical note that symptoms were related to medication and that there was no weight loss over time nor tenderness on examination. The guidelines indicate that a complete examination including an internal examination is necessitated prior to laboratory evaluation and imaging. The request is not medically necessary and appropriate.

MRI Lumbar Spine QTY 1: Upheld

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

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

Decision rationale: Per ACOEM, unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. The physical examination does not detail any neurologic deficits that would require an MRI nor were there EMG/NCV showing neurologic dysfunction, which would require an MRI. The request is not medically necessary and appropriate.

MRI bilateral knees QTY 2: Upheld

Claims Administrator guideline: Decision based on MTUS Knee Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Knee Complaints 2004, Section(s): Special Studies.

Decision rationale: Per ACOEM guidelines, special studies are not needed to evaluate most knee complaints until after a period of conservative care and observation. The position of the American College of Radiology (ACR) in its most recent appropriateness criteria list the following clinical parameters as predicting absence of significant fracture and may be used to support the decision not to obtain a radiograph following knee trauma: patient is able to walk without a limp, patient had a twisting injury and there is no effusion. The clinical parameters for ordering knee radiographs following trauma in this population are: joint effusion within 24 hours of direct blow or fall, palpable tenderness over fibular head or patella, inability to walk (four steps) or bear weight immediately or within a week of the trauma, inability to flex knee to 90 degrees. Most knee problems improve quickly once any red-flag issues are ruled out. Reliance only on imaging studies to evaluate the source of knee symptoms may carry a significant risk of diagnostic confusion (false-positive test results) because of the possibility of identifying a problem that was present before symptoms began, and therefore has no temporal association with the current symptoms. There is notation in the documentation that the IW had already undergone MRI of the lower extremities. There was no notation of new trauma that would require reimaging of the knees. The request is not medically necessary and appropriate.

X-ray lumbar spine QTY 1: Upheld

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

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

Decision rationale: Per ACOEM, lumbar spine x rays should not be recommended in patients with low back pain in the absence of red flags for serious spinal pathology, even if the pain has persisted for at least six weeks. Red flags include suspicions of tumor, infection, fracture, or dislocation. A history of tumor, infection, abdominal aneurysm, or other related serious conditions, together with positive findings on examination. There is no documentation of any red flags in the case file. The request is not medically necessary and appropriate.

X-ray Pelvis QTY 1: 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), Hip & Pelvis (updated 10/9/14), Online Version, X-rays.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip & Pelvis - X-rays.

Decision rationale: Per ODG, plain radiographs (X-Rays) of the pelvis should routinely be obtained in patients sustaining a severe injury. X-Rays are also valuable for identifying patients with a high risk of the development of hip osteoarthritis. Plain radiographs are usually sufficient for diagnosis of hip fracture as they are at least 90% sensitive. Standard radiographic hip imaging includes antero-posterior (AP) pelvic projection with dedicated AP and cross-table lateral projections of the affected hip. Conventional estimates have put the sensitivity of these projections for hip fracture between 90% and 98%. This study highlights the limitations of radiography in detecting hip or pelvic pathologic findings, including fractures, as well as soft-tissue pathologic findings. MRI shows superior sensitivity in detecting hip and pelvic fractures over plain film radiography. The IW had already undergone extensive imaging and treatment after the injury and there was no subsequent trauma that would require reimaging. The request is not medically necessary and appropriate.

X-ray bilateral knees QTY 2: Upheld

Claims Administrator guideline: Decision based on MTUS Knee Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Knee Complaints 2004, Section(s): Special Studies.

Decision rationale: Per ACOEM guidelines, special studies are not needed to evaluate most knee complaints until after a period of conservative care and observation. The position of the American College of Radiology (ACR) in its most recent appropriateness criteria list the following clinical parameters as predicting absence of significant fracture and may be used to support the decision not to obtain a radiograph following knee trauma: patient is able to walk without a limp, patient had a twisting injury and there is no effusion. The clinical parameters for ordering knee radiographs following trauma in this population are: joint effusion within 24 hours of direct blow or fall, palpable tenderness over fibular head or patella, inability to walk (four steps) or bear weight immediately or within a week of the trauma, inability to flex knee to 90 degrees. Most knee problems improve quickly once any red-flag issues are ruled out. Reliance only on imaging studies to evaluate the source of knee symptoms may carry a significant risk of diagnostic confusion (false-positive test results) because of the possibility of identifying a problem that was present before symptoms began, and therefore has no temporal association with the current symptoms. There is notation in the documentation that the IW had already undergone x-rays of the lower extremities. There was no notation of new trauma that would require reimaging of the knees. The request is not medically necessary and appropriate.

X-ray bilateral hips QTY 2: 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), Hip & Pelvis (updated 10/9/14), Online Version, X-rays.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip & Pelvis - X-rays.

Decision rationale: Per ODG, plain radiographs (X-Rays) of the pelvis should routinely be obtained in patients sustaining a severe injury. X-Rays are also valuable for identifying patients with a high risk of the development of hip osteoarthritis. Plain radiographs are usually sufficient for diagnosis of hip fracture as they are at least 90% sensitive. Standard radiographic hip imaging includes antero-posterior (AP) pelvic projection with dedicated AP and cross-table lateral projections of the affected hip. Conventional estimates have put the sensitivity of these projections for hip fracture between 90% and 98%. This study highlights the limitations of radiography in detecting hip or pelvic pathologic findings, including fractures, as well as soft-tissue pathologic findings. MRI shows superior sensitivity in detecting hip and pelvic fractures over plain film radiography. The IW had already undergone extensive imaging and treatment after the injury and there was no subsequent trauma that would require reimaging. The request is not medically necessary and appropriate.