

Case Number:	CM15-0067878		
Date Assigned:	04/15/2015	Date of Injury:	10/28/2010
Decision Date:	05/14/2015	UR Denial Date:	03/12/2015
Priority:	Standard	Application Received:	04/09/2015

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: California, Indiana, New York
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 51 year old male who sustained an industrial injury on 10/28/10. The mechanism of injury is unclear. He currently complains of constant neck and low back pain radiating to bilateral upper and lower extremities with numbness and tingling. His pain level is 7-8/10. He is able to perform self-care. He is limited in stair climbing. He has sleep disturbances. Per progress note 10/21/14 it was noted that the injured worker naps, stops breathing during sleep. Sleep hygiene has been discussed. He uses sleep aid three to four times per week and is able to get only 3-4 hours of sleep. No sleep study has been done to date. Medications are Prilosec, Sentra, Norco, Soma and ranitidine, and Colace. Diagnoses include cervical disc protrusion, spinal stenosis and radiculopathy; lumbago; lumbar radiculopathy ; constipation, secondary to narcotics; gastroesophageal reflux disease with H. pylori; hemorrhoids, secondary to constipation and anxiety. Treatments to date include medications, home exercise program. Diagnostics included normal electrocardiogram, chest x-ray. There was no effort made on pulmonary function test so it had no significant clinical value. In the progress note dated 1/9/15 the treating provider's plan of care recommends cardio-respiratory testing, Autonomis Function Assessment: cardiovagal Innervation, Vasomotor Adrenergic Innervation; Pulmonary function Tests and diagnostic testing. The specific diagnostic testing to rule out was not specified in the records reviewed. The Utilization Review specified Recombinant Polymerase Amplification; Sleep Disorder Breathing; Obstructive Sleep Apnea; Central Serous Retinopathy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cardio innervation: 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/15724139.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines History and Physical Assessment Page(s): 5-6. Decision based on Non-MTUS Citation <http://www.ncbi.nlm.nih.gov/pubmed/15724139>.

Decision rationale: Pursuant to the Chronic Pain Medical Treatment Guidelines, cardio innervation is not medically necessary. The autonomic nervous system plays an important role in the regulation of cardiac function and the regional distribution of cardiac nerve terminals can be visualized using scintigraphic techniques. Although innervation imaging holds great promise for clinical use, the method has not received wider clinical acceptance. Larger randomized studies are required to confirm the value of innervation imaging in various specific indications. Thorough history taking is there always important in the clinical assessment and treatment planning for the patient with chronic pain and includes a review of medical records. Clinical recovery may be dependent on identifying and addressing previously unknown or undocumented medical or psychosocial issues. A thorough physical examination is also important to establish/confirm diagnoses and observe/understand pain behavior. The history and physical examination serves to establish reassurance and patient confidence. Diagnostic studies should be ordered in this context and not simply for screening purposes. In this case, the injured workers working diagnoses are cervical disc protrusion; cervical spinal stenosis; cervical radiculopathy; lumbago; lumbar radiculopathy; and anxiety. Subjectively, in a progress note dated February 4, 2015, the injured worker as complaints of neck and low back pain 7-8/10 radiating to the bilateral upper and lower extremities with numbness and tingling. Objectively, cervical range of motion is decreased and there is tenderness palpation along the cervical spine. There is tenderness and spasm along the trapezius muscles bilaterally. Lumbar range of motion is decreased. There is tenderness to palpation along the lumbar spine. There is no clinical indication or clinical rationale for cardio innervation in the medical record. The documentation of progress note dated February 4, 2015 contains musculoskeletal subjective and objective findings. There is no discussion of cardio information, autonomic dysfunction, heart related maladies, obstructive sleep apnea, etc. The injured worker underwent a QME on January 26, 2015. An electrocardiogram and chest x-ray was normal. Pulmonary function tests were attempted but were of no clinical significance. Consequently, absent clinical documentation with a clinical indication or rationale for cardio innervation, cardio innervation is not medically necessary.

Vasomotor adrenergic innervation: 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/15724139.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines History and Physical Assessment Page(s): 5-6. Decision based on Non-MTUS Citation http://www.aetna.com/cpb/medical/data/400_499/0485.html.

Decision rationale: Pursuant to the Chronic Pain Medical Treatment Guidelines, vasomotor adrenergic innervation is not medically necessary. Thorough history taking is there always important in the clinical assessment and treatment planning for the patient with chronic pain and includes a review of medical records. Clinical recovery may be dependent on identifying and addressing previously unknown or undocumented medical or psychosocial issues. A thorough physical examination is also important to establish/confirm diagnoses and observe/understand pain behavior. The history and physical examination serves to establish reassurance and patient confidence. Diagnostic studies should be ordered in this context and not simply for screening purposes. In this case, the injured workers working diagnoses are cervical disc protrusion; cervical spinal stenosis; cervical radiculopathy; lumbago; lumbar radiculopathy; and anxiety. Subjectively, in a progress note dated February 4, 2015, the injured worker as complaints of neck and low back pain 7-8/10 radiating to the bilateral upper and lower extremities with numbness and tingling. Objectively, cervical range of motion is decreased and there is tenderness palpation along the cervical spine. There is tenderness and spasm along the trapezius muscles bilaterally. Lumbar range of motion is decreased. There is tenderness to palpation along the lumbar spine. There is no clinical indication or clinical rationale for vasomotor adrenergic innervation. The documentation of progress note dated February 4, 2015 contains musculoskeletal subjective and objective findings. There is no discussion of cardio information, autonomic dysfunction, heart related maladies, obstructive sleep apnea, etc. The injured worker underwent a QME on January 26, 2015. An electrocardiogram and chest x-ray was normal. Pulmonary function tests were attempted but were of no clinical significance. Consequently, absent clinical documentation with a clinical indication or rationale for vasomotor adrenergic innervation, vasomotor adrenergic innervation is not medically necessary.

Diagnostic testing to rule out RPA, SDB, OSA, and CSR: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Journal of Clinical Neurology, Autonomic function tests, Official Disability Guidelines (ODG), Low Back.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines History and Physical Assessment Page(s): 5-6.

Decision rationale: Pursuant to the Chronic Pain Medical Treatment Guidelines, diagnostic testing to rule out recombinant polymerase amplification (RPA), sleep disordered breathing (SDB), obstructive sleep apnea (OSA), and central serous retinopathy (CSR) are not medically necessary. Thorough history taking is there always important in the clinical assessment and treatment planning for the patient with chronic pain and includes a review of medical records. Clinical recovery may be dependent on identifying and addressing previously unknown or undocumented medical or psychosocial issues. A thorough physical examination is also important to establish/confirm diagnoses and observe/understand pain behavior. The history and physical examination serves to establish reassurance and patient confidence. Diagnostic studies

should be ordered in this context and not simply for screening purposes. In this case, the injured workers working diagnoses are cervical disc protrusion; cervical spinal stenosis; cervical radiculopathy; lumbago; lumbar radiculopathy; and anxiety. Subjectively, in a progress note dated February 4, 2015, the injured worker has complaints of neck and low back pain 7-8/10 radiating to the bilateral upper and lower extremities with numbness and tingling. Objectively, cervical range of motion is decreased and there is tenderness palpation along the cervical spine. There is tenderness and spasm along the trapezius muscles bilaterally. Lumbar range of motion is decreased. There is tenderness to palpation along the lumbar spine. There is no clinical indication or clinical rationale for recombinant polymerase amplification, sleep disordered breathing, obstructive sleep apnea, and central serous retinopathy. The documentation of progress note dated February 4, 2015 contains musculoskeletal subjective and objective findings. There is no discussion of cardio information, autonomic dysfunction, heart related maladies, obstructive sleep apnea, etc. The injured worker underwent a QME on January 26, 2015. An electrocardiogram and chest x-ray was normal. Pulmonary function tests were attempted but were of no clinical significance. Consequently, absent clinical documentation with a clinical indication or rationale for diagnostic testing, diagnostic testing to rule out recombinant polymerase amplification (RPA), sleep disordered breathing (SDB), obstructive sleep apnea (OSA), and central serous retinopathy (CSR) are not medically necessary.