

Case Number:	CM13-0066167		
Date Assigned:	04/11/2014	Date of Injury:	05/14/2013
Decision Date:	05/27/2014	UR Denial Date:	11/14/2013
Priority:	Standard	Application Received:	12/16/2013

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 patient is a 71 year old male who was injured on 05/14/2013 when he fell onto the ground from a stool, landing on his left hand. Office note dated 09/11/2013 indicated the patient presented with complaints of numbness of the bilateral hands and bilateral feet. Objective findings on exam revealed non-diffuse tenderness mainly of left paraspinous; Straight leg raise was 60 bilaterally. His neck pain was dull, non-radiating, occurred 50% of the time, and interfered with the applicant's ability to carry, lift, pull, push, reach above the shoulder, and reach overhead. The applicant denied ever having had either x-rays or MRI of the neck. The left shoulder pain was sharp, radiated to the left arm, occurring 100% of the time and interfered with the applicant's ability to carry, lift, pull, push, reach above the shoulder, and reach overhead. The left hip pain was sharp, radiated to the leer back and left thigh, occurring 100% of the time, and interfered with the patient's ability to bend at the waist, carry, lift, pull, push, sit, squat, stand, and walk. Reflexes were 1 in all muscle groups bilaterally; Babinski, Tinel's and Hoffman tests were negative. Phalen's was negative on the right but the left exhibited shoulder pain. There was swelling of the bilateral shoulders with non-diffuse tenderness of the left shoulder mainly anterior. There was swelling of the bilateral hips; with non-diffuse left hip mainly posterior lateral. Vascular examination revealed left TCAFO. The patient was diagnosed with cervical spine strain, left shoulder strain, and left hip strain.

IMR ISSUES, DECISIONS AND RATIONALES

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

PHYSIOTHERAPY 3 TIMES 6 TO THE LEFT SHOULDER,: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-9.

Decision rationale: The California MTUS guidelines recommend physical medicine up to 10 visits over 8 weeks for the body part in question. Further authorization should be dependent upon demonstration of functional improvement. While physical therapy appears indicated in this case, 18 visits exceed guideline recommendations. A rationale for excessive visits is not provided. The medical necessity is not established.

MRI CERVICAL: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

Decision rationale: This is a request for MRI of the cervical spine for chronic neck pain secondary to a fall on 5/14/13. The patient reportedly has pain radiation into the upper extremities, but details are lacking. There are no documented signs of radiculopathy on examination. There is no evidence of progressive neurologic deficit. The California MTUS guidelines recommend cervical MRI for chronic pain after failure of conservative treatment or abnormal radiographs. However, XR's had not been taken at the time of the request, and there had not been conservative treatment other than rest. The medical necessity is not established at this time.

MRI LEFT SHOULDER: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 206-209.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 206-209.

Decision rationale: This is a request for left shoulder MRI for chronic pain from a fall on 5/14/13. The California MTUS guidelines recommend shoulder MRI for suspected rotator cuff tear, impingement or acute trauma suggestive of internal derangement. However, the patient does not have documented symptoms or signs on exam suggestive of significant shoulder pathology. MRI is simply being ordered given the long duration of the patient's symptoms. No L shoulder XR results are provided. Conservative care such as physical medicine has not been performed. The medical necessity is not established.

MRI LEFT HIP: 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.

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, MRI.

Decision rationale: This is a request for left hip MRI for chronic pain from a fall on 5/14/13. ODG guidelines recommend hip MRI to evaluate suspected pathology after plain films have been performed. However, plain films are not provided. The patient does not have documented symptoms or signs on exam suggestive of significant hip pathology. MRI is simply being ordered given the long duration of the patient's symptoms. Conservative care such as physical medicine has not been performed. The medical necessity is not established.

EMG/NCS TO BILATERAL UPPER EXTREMITIES: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

Decision rationale: This is a request for EMG/NCS for bilateral upper extremities. The California MTUS guidelines recommend EMG/NCV to help identify focal neurologic dysfunction. However, while there is mention of radiating pain into the upper extremities, the character and specific location are not described. There is no numbness or weakness. There are no described signs of radiculopathy on examination. There is no specific rationale provided for this study. The medical necessity is not established.

EMG/NCS TO LEFT LOWER EXTREMITY: 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): 303.

Decision rationale: This is a request for EMG/NCS for the left lower extremity. The California MTUS guidelines recommend EMG/NCV to help identify focal neurologic dysfunction. However, while there is mention of radiating pain into the lower extremity, the character and specific location are not described. There is no numbness or weakness. There are no described signs of radiculopathy on examination. There is no specific rationale provided for this study. The medical necessity is not established.

DIGITAL RANGE OF MOTION TESTING: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Cervical Spine, Knee and Low Back Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Cervical, Low Back, Computerized Range of Motion, Flexibility.

Decision rationale: This is a request for digital range of motion testing. According to ODG, inclinometers are recommended for range of motion testing. Computerized measures are not recommended as there does not appear to be any significant advantage over the inclinometer. The medical necessity is not established.

DIGITAL ELECTRONIC MYOMETRY: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Cervical Spine, Knee And Low Back Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Cervical, Low Back, Knee.

Decision rationale: This is a request for digital electronic myometry. According to ODG guidelines, computerized strength testing of the extremities is not recommended as there are no studies to support it, and conventional measures of strength testing are adequate. The medical necessity is not established.

DIGITAL ELECTRONIC GRIP STRENGTH TESTING: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Cervical Spine, Knee, And Low Back Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Cervical, Low Back, Knee.

Decision rationale: This is a request for digital electronic grip strength testing. According to ODG guidelines, computerized strength testing of the extremities is not recommended as there are no studies to support it, and conventional measures of strength testing are adequate. Furthermore, there are no documented complaints of weakness nor is there weakness described on physical examination. The medical necessity is not established.

COMPUTERIZED SENSORY TESTING: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Cervical Spine, Knee, And Low Back Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Cervical, Current Perception Threshold.

Decision rationale: This is request for computerized sensory testing. According to ODG, this test is not recommended. "There are no clinical studies demonstrating that quantitative tests of sensation improve the management and clinical outcomes of patients over standard qualitative methods of sensory testing." Further, there are no described complaints of decreased sensation nor are there examination findings of decreased sensation. The medical necessity is not established.