

Case Number:	CM14-0004290		
Date Assigned:	02/05/2014	Date of Injury:	09/19/2012
Decision Date:	06/20/2014	UR Denial Date:	01/06/2014
Priority:	Standard	Application Received:	01/10/2014

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 Physical Medicine & Rehabilitation 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 an employee of [REDACTED] and has submitted a claim for low back pain associated with an industrial injury date of September 19, 2012. Treatment to date has included medications, physical therapy for three months, and unknown number of sessions of aquatic therapy for the lumbar spine, chiropractic treatment, acupuncture, and right shoulder steroid injection. Medical records from 2013 were reviewed, which showed that the patient complained of low back pain. She also had stiffness and pain in the cervical spine with difficulties with overhead activities in her right shoulder. The right knee was asymptomatic. On physical examination of the cervical spine, there was paraspinal muscle tenderness with painful but normal range of motion. No atrophy, fasciculation, or sensor motor deficits of the upper extremities were noted. Examination of the right shoulder revealed no deformity or spasm but tenderness was reported. Range of motion was slightly limited. There was weakness of the right shoulder. Examination of the acromioclavicular and sternoclavicular joints and rotator cuff was unremarkable. No instability of the shoulder was noted. Examination of the right knee revealed normal range of motion with no evidence of atrophy but motor strength was decreased. Sensation and reflexes were intact. Patella, quadriceps, meniscus, and ligamentous exam was unremarkable. Utilization review from January 6, 2014 denied the request for MRI of right knee because a detailed knee exam was not provided; aquatic therapy 2x6 to cervical spine/right shoulder because the patient had extensive physical therapy but no benefit was documented; and MRI of right shoulder because there was no documentation of red flag signs.

IMR ISSUES, DECISIONS AND RATIONALES

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

MAGNETIC RESONANCE IMAGING (MRI) OF RIGHT KNEE: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 13-1.

Decision rationale: According to the ACOEM Practice Guidelines referenced by CA MTUS, MRI is recommended for an unstable knee with documented episodes of locking, popping, giving way, current effusion, clear signs of a bucket handle tear, and to determine extent of ACL tear preoperatively. In this case, the latest medical report stated that the patient's right knee was asymptomatic. Aside from mild motor weakness, the rest of the physical examination findings of the right knee were unremarkable. There is no clear indication for an MRI of the right knee at this time; therefore, the request for Magnetic Resonance Imaging (MRI) of right knee is not medically necessary.

AQUATIC THERAPY TWO TIMES SIX TO CERVICAL SPINE/RIGHT SHOULDER: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines. Decision based on Non-MTUS Citation MTUS: , AQUA THERAPY,

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Page(s): 22.

Decision rationale: According to page 22 of the CA MTUS Chronic Pain Medical Treatment Guidelines, aquatic therapy is recommended as an optional form of exercise therapy, where available, as an alternative to land-based physical therapy when reduced weight bearing is indicated, such as with extreme obesity. In this case, the patient had an unknown number of aquatic therapies to the lumbar spine but there was no documentation regarding aquatic therapy to the cervical spine or right shoulder. However, the medical records failed to provide a discussion regarding the necessity for aquatic therapy, such as the need for reduced weight bearing. There is no clear indication for prescribing aquatic therapy over land-based therapy; therefore, the request for aquatic therapy two times six to cervical spine/right shoulder is not medically necessary

MAGNETIC RESONANCE IMAGING (MRI) OF RIGHT SHOULDER: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 208-209.

Decision rationale: According to pages 179-180 of the ACOEM Practice Guidelines referenced by CA MTUS, criteria for imaging include emergence of a red flag; physiologic evidence of tissue insult or neurologic dysfunction; failure to progress in a strengthening program; and clarification of the anatomy prior to an invasive procedure. In this case, there was no documentation of red flags and aside from mild weakness or decreased range of motion of the right shoulder, there was no evidence of specific neurologic dysfunction. There was also no discussion regarding failure of a strengthening program. There was also no discussion regarding possible future interventional plans that may warrant clarification of shoulder anatomy. The criteria were not met; therefore, the request for Magnetic Resonance Imaging (MRI) of right shoulder is not medically necessary.