

Case Number:	CM14-0127965		
Date Assigned:	08/15/2014	Date of Injury:	02/05/2010
Decision Date:	09/23/2014	UR Denial Date:	07/22/2014
Priority:	Standard	Application Received:	08/12/2014

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 Family Medicine and is licensed to practice in North Carolina. 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 63-year-old with a reported date of injury of 02/05/2010. The patient has the diagnoses of left knee pain, left knee chondromalacia, medial compartment/patellofemoral compartment and medial meniscal tear and right shoulder pain. Previous treatment modalities have included physical therapy. Per the progress notes provided by the primary treating physician dated 07/10/2014, the patient had complaints of left knee pain and right shoulder pain that was improving with physical therapy. Physical exam noted pain with O'Brien's sign/empty can sign in the right shoulder. The knee had positive impingement and tenderness to palpation in the bilateral joint lines. Previous MRI from 05/30/2014 confirmed medial compartment cartilage wear and medial meniscal tear. Treatment recommendations included request for right shoulder MRI, lubrication shot for the left knee and refill on pain medication.

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 the 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): 207-210.

Decision rationale: The ACOEM chapter on shoulder complaints states the following are primary indications for imaging studies of the shoulder: be correlated with physical findings. Primary criteria for ordering imaging studies are: - Emergence of a red flag (e.g., indications of intra-abdominal or cardiac problems presenting as shoulder problems)- Physiologic evidence of tissue insult or neurovascular dysfunction (e.g., cervical root problems presenting as shoulder pain, weakness from a massive rotator cuff tear, or the presence of edema, cyanosis or Raynaud's phenomenon)- Failure to progress in a strengthening program intended to avoid surgery.- Clarification of the anatomy prior to an invasive procedure (e.g., a full thickness rotator cuff tear not responding to conservative treatment) Per table 9-6 routine MRI not for surgical considerations is not recommended. This patient has no emergence of red flags or evidence of tissue insult or neurovascular dysfunction on documented physical exam. The patient is reported to be slowly improving with physical therapy and thus not failing in a strengthening program. There is also no mention of a planned surgical intervention. For these reasons criteria for a MRI has not been met and thus not certified.

Synvisc series of injections once a week for three weeks: 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).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) knee chapter.

Decision rationale: The California MTUS and the ACOEM do not specifically address the requested service. The ODG states: Recommended as a possible option for severe osteoarthritis for patients who have not adequately responded to recommended conservative treatment (exercise, NSAIDs or acetaminophen), to possibly delay total knee replacement, however, in recent quality studies the magnitude of improvement appears modest at best. While osteoarthritis of the knee is a recommended indication, there is insufficient evidence for other conditions including patellofemoral arthritis, chondromalacia patella, osteochondritis dissecans or patellofemoral syndrome. Criteria include patients experiencing significantly symptomatic osteoarthritis who have not responded adequately to recommended conservative non-pharmacologic and pharmacologic treatments or are intolerant to these therapies after at least 3 months. This patient has MRI findings of medial compartment cartilage wear and medial meniscal tear. The patient does not have the indicated diagnoses of severe osteoarthritis. There is also no documented evidence of failure of conservative pharmacologic treatments. For these reasons criteria has not been met as outlined above and the service is not certified.

Physical therapy two times a week for six weeks: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines physical medicine Page(s): 98-99.

Decision rationale: The California chronic pain medical treatment guidelines section on physical medicine states: Recommended as indicated below. Passive therapy (those treatment modalities that do not require energy expenditure on the part of the patient) can provide short term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. They can be used sparingly with active therapies to help control swelling, pain and inflammation during the rehabilitation process. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. Physical Medicine Guidelines - Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. Myalgia and myositis, unspecified (ICD9 729.1): 9-10 visits over 8 weeks Neuralgia, neuritis, and radiculitis, unspecified (ICD9 729.2) 8-10 visits over 4 weeks Reflex sympathetic dystrophy (CRPS) (ICD9 337.2): 24 visits over 16 weeks The patient has the diagnosis of knee pain and shoulder pain. There is mention of slow improvement of the shoulder pain with physical therapy. However, there is no documentation of how many physical therapy sessions the patient had completed and why a fading of treatment frequency to active self-directed home therapy would not be indicated. In the absence of such documentation, compliance with guideline recommendations cannot be verified and thus the request cannot be certified.