

<b>Case Number:</b>	CM14-0154201		
<b>Date Assigned:</b>	10/07/2014	<b>Date of Injury:</b>	04/08/2014
<b>Decision Date:</b>	10/31/2014	<b>UR Denial Date:</b>	09/05/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/22/2014

### 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 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:

Injured worker is a female with date of injury 4/8/2014. Per primary treating physician's progress report dated 8/20/2014, the injured worker complains of intermittent moderate to severe cervical spine pain that was described as pinching. The pain was aggravated by bending her neck forward. There were complaints of intermittent moderate to severe headaches that she described as sharp and throbbing. The pain was aggravated by neck pain. She has frequent moderate to severe left knee pain that was described as sharp and was made worse by walking up steps. She complained of intermittent severe right forearm pain that was described as sharp shooting and burning. She complained of moderate pain in bilateral wrists and hands that was described as sore. The pain was aggravated by gripping and grasping. She reported the pain radiates to her thumb. There were complaints of intermittent moderate to severe pain that was best described as sharp and throbbing. Pain was made worse by bending forward. On examination there was +3 spasm and tenderness to the bilateral paraspinal muscles from C4 to C7, bilateral suboccipital muscles and bilateral upper shoulder muscles. Axial compression test was positive bilaterally for neurological compromise. Distraction test was positive bilaterally. Shoulder depression test was positive bilaterally. The right triceps reflex was decreased. There was +3 spasm and tenderness to the bilateral paraspinal muscles from T1 to T9. Kemp's was positive bilaterally. There was +3 spasm and tenderness to the right wrist flexor and extensor muscles midbelly and at their origin. Elbow range of motion was measured by an external goniometer or digital protractor. Cozen's test was positive on the right. Reverse Cozen's test was positive on the right. There was +3 spasm and tenderness to the bilateral anterior wrists and posterior extensor tendons. Bracelet test was positive bilaterally. Phalen's and Finklestein's was negative. Left wrist Jamar dynamometer readings were 15/0/0. Right Jamar dynamometer readings were 15/6/4. There was +3 spasm and tenderness to the left anterior joint line, vastus medialis and popliteal fossa. Anterior-posterior

drawer test was positive on the left. Posterior-anterior drawer test was positive on the left. McMurray's test was positive on the left. Diagnoses include 1) traumatic spondylopathy of the cervical spine 2) cervical disc herniation without myelopathy 3) thoracic disc displacement without myelopathy 4) cruciate ligament sprain of the left knee 5) tear of lateral meniscus of the left knee 6) lateral epicondylitis of the right elbow 7) medial epicondylitis of the right elbow 8) carpal sprain/strain of the bilateral wrists 9) headache, tension.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**10 visits for a program of work hardening/conditioning: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation State of California Worker's Compensation Official Medical Fee Schedule, 4/1/1999 revision, page 503-504

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Work Conditioning, Work Hardening section Page(s): 125, 126.

**Decision rationale:** The MTUS Guidelines recommend the use of work hardening as an option, depending on the availability of quality programs. Criteria for admission to a work hardening program include 1) work related musculoskeletal condition with functional limitations precluding ability to safely achieve current job demands, which are in the medium or higher demand level 2) after treatment with an adequate trial of physical or occupational therapy with improvement followed by plateau, but not likely to benefit from continued physical or occupational therapy, or general conditioning 3) not a candidate where surgery or other treatments would clearly be warranted to improve function 4) physical and medical recovery sufficient to allow for progressive reactivation and participation for a minimum of 4 hours a day for three to five days a week 5) A defined return to work goal agreed to by the employer and employee 6) the worker must be able to benefit from the program 7) the worker must be no more than 2 years past date of injury 8) work hardening programs should be completed in 4 weeks consecutively or less 9) treatment is not supported for longer than 1-2 weeks without evidence of patient compliance and demonstrated significant gains as documented by subjective and objective gains and measurable improvement in functional abilities 10) upon completion of a rehabilitation program, neither re-enrollment in nor repetition of the same or similar rehabilitation program is medically warranted for the same condition or injury. The injured worker has not had a failure of returning to work. She is currently working with work restrictions. Medical necessity of this request has not been established. The request for 10 visits for a program of work hardening/conditioning is determined to not be medically necessary.

**Unknown sessions of additional therapeutic procedures to include: electrical muscle stimulation to the right elbow and left knee, infrared to the cervical spine and bilateral wrists, paraffin, and grip strength: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Elbow (Acute & Chronic) Official Disability Guidelines, Knee & Leg

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine section Page(s): 98-99.

**Decision rationale:** The MTUS Guidelines recommend physical therapy focused on active therapy to restore flexibility, strength, endurance, function, range of motion and alleviate discomfort. The MTUS Guidelines support physical therapy that is providing a documented benefit. Physical therapy should be provided at a decreasing frequency (from up to 3 visits per week to 1 or less) as the guided therapy becomes replaced by a self-directed home exercise program. The physical medicine guidelines recommend myalgia and myositis, unspecified; receive 9-10 visits over 8 weeks. The MTUS Guidelines recommend active therapy focused on functional improvement over passive modalities which are primarily to provide comfort. This request was specifically to be in conjunction with the request for work hardening, which was determined to not be medically necessary. Medical necessity of this request has not been established within the recommendations of the MTUS Guidelines. The request for Unknown sessions of additional therapeutic procedures to include: electrical muscle stimulation to the right elbow and left knee, infrared to the cervical spine and bilateral wrists, paraffin, and grip strength is determined to not be medically necessary.

**1 urinalysis:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Urine drug testing.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Drug Testing section, Opioids Criteria for Use section Page(s): 43, 112.

**Decision rationale:** The use of urine drug screening is recommended by the MTUS Guidelines, in particular when patients are being prescribed opioid pain medications and there are concerns of abuse, addiction, or poor pain control. The injured worker is not currently being prescribed opioid pain medications. There are no documented concerns of abuse, addition or poor pain control. Medical necessity of this request has not been established within the recommendations of the MTUS Guidelines. The request for 1 urinalysis is determined to not be medically necessary.

**1 MRI 3D cervical spine and thoracic spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-8.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

**Decision rationale:** Per the MTUS Guidelines, if physiologic evidence indicates tissue insult or nerve impairment, an MRI may be necessary. Other criteria for special studies are also not met, such as emergence of a red flag; failure to progress in a strengthening program intended to avoid surgery, and clarification of the anatomy prior to an invasive procedure. The injured worker is not reported to meet the criteria within the MTUS Guidelines that would support the use of an MRI. The request for 1 MRI 3D cervical spine and thoracic spine is determined to not be medically necessary.