

<b>Case Number:</b>	CM14-0035562		
<b>Date Assigned:</b>	07/23/2014	<b>Date of Injury:</b>	08/16/2013
<b>Decision Date:</b>	09/08/2014	<b>UR Denial Date:</b>	02/19/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/22/2014

### 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 Physical medicine and 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 injured worker is a 62 year old female with date of injury 8/16/13. The injured worker complains of moderate to severe pain in the neck area with radiation to both shoulders, in lower back with radiation and numbness into buttocks and legs, in both wrists / hands, in both shoulders and both knees which is aggravated with walking, stairs, and prolonged standing. On exam, she has tenderness and spasm in the cervical and lumbar paraspinal muscles. Distraction test was positive bilaterally. Shoulder depression test was positive bilaterally. The reflex was decreased in both triceps. Straight leg raising was positive on the left. Yeoman's was positive bilaterally. At wrists, there is tenderness at bilateral anterior wrists, posterior extensor tendons, and thenar muscles. Tinel's sign was positive bilaterally. Phalen's test was positive bilaterally. There was also tenderness at both knee joint lines. McMurray's test and Clarke's tests were positive bilaterally. Her diagnoses were cervical disc herniation with myelopathy, lumbar spondylosis with myelopathy, partial tear of rotator cuff tendon bilaterally, bilateral carpal tunnel syndrome, bilateral wrists tendinitis, chondromalacia patella, bilateral knee bursitis, and anxiety. She has completed 20 sessions of physical medicine and reached a plateau in her recovery.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**3D MRI of the cervical spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 181-183.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back (Acute & Chronic), Magnetic resonance imaging (MRI).

**Decision rationale:** As per guidelines, the primary criteria for ordering imaging studies are emergence of a red flag, or clarification of the anatomy prior to an invasive procedure or when the X-Ray studies are non-diagnostic. Furthermore, as per guidelines, unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies if symptoms persist. In this case, this injured worker reports neck pain. However, there is no record of prior X-Ray studies, no clear neurological deficits; i.e. decreased sensation, strength or atrophy in bilateral upper extremities to warrant cervical magnetic resonance imaging. The triceps reflex was noted decreased; however it is symmetrical and no grading is mentioned. There are no neurological abnormalities indicative of a diagnosis of myelopathy (as suggested by the physician), such as positive Hoffman, Babinski or clonus. Thus, the request for magnetic resonance imaging of the cervical spine is not medically necessary.

**3D MRI's of bilateral knees:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee & Leg Chapter, Indications for Imaging: Magnetic Resonance Imaging (MRI).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg (Acute & Chronic), MRI's (magnetic resonance imaging).

**Decision rationale:** Per guidelines, magnetic resonance imaging of the knee is indicated when there is acute or severe trauma to the knee joint, or when the X-Ray of the knee joint is non-diagnostic, or when there is evidence of internal derangement. In this case, there is no record of prior X-Ray for knee evaluation. There is no evidence of severe trauma. The injured worker is noted to have pain in the knee joints and positive Clarke which are indicative of possible degenerative joint disease and patellofemoral syndrome. The McMurray test was also positive (possibly indicative of meniscus tear or degeneration). There is no plan for any surgical intervention. There are no red flags. There is no ambiguity in the diagnosis. Therefore, the request is considered not medically necessary per guideline.

**Additional Physical Therapy times 6 to bilateral wrists/hands, neck, low back, left shoulder and bilateral knees:** 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.

**Decision rationale:** As per CA MTUS guidelines, physical medicine 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. The guidelines recommend 9-10 visits for myalgia and myositis and 8-10 visits for neuralgia, neuritis, and radiculitis. The injured worker has already had 20 visits and reached her plateau. Furthermore, she is expected to perform home exercise program as maintenance. Thus, since the prior trial did not result in functional improvement and the request for 6 sessions exceed the guidelines recommendation, the request is considered not medically necessary and appropriate.

**Chiropractic Therapy times 6 to the cervical spine and lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation Page(s): 58-59.

**Decision rationale:** According to the CA MTUS guidelines, chiropractic treatment may be appropriate for treatment of chronic pain. Manipulation is helpful in improving function, decreasing pain and improving quality of life. The goal is to achieve positive symptomatic or objective measurable gains in functional improvement. The injured worker is noted that has already had 20 visits of physical therapy and reached her plateau. The medical records provided do not establish the need for further manipulations and follow up visits with a chiropractor. Based on the documentation and guidelines, the request is not medically necessary.

**Psychosocial Factors Screening / Evaluation:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Psychological Evaluations Page(s): 100.

**Decision rationale:** As per CA MTUS guidelines, the occupational health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. Further guidelines indicate consultation is recommended to aid in the diagnosis, prognosis, therapeutic management, determination of medical stability, and permanent residual loss and/or the examinee's fitness for return to work. In this case, the specific need for this request is not mentioned. Furthermore, there is no documentation of a thorough evaluation with respect to psychological issues by the physician or her primary care physician. Hence, the request for psychological consultation is not medically necessary.

**Work Hardening Screening / Evaluation:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Work Hardening/Work Conditioning.

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

**Decision rationale:** The guidelines state criteria for admission to work hardening program such as a defined return to work goal, after adequate physical therapy with improvement, and no plan for surgery. In this case, there is no documentation of any plan for return to work and there is little to no evidence of any improvement with physical therapy. Therefore, the request is considered not medically necessary per guidelines.