

Case Number:	CM14-0212902		
Date Assigned:	02/11/2015	Date of Injury:	06/13/2014
Decision Date:	04/21/2015	UR Denial Date:	11/21/2014
Priority:	Standard	Application Received:	12/19/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: New York
 Certification(s)/Specialty: Emergency Medicine

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 58 year old male who has reported the gradual onset of widespread pain attributed to usual work activity with a listed injury date of 06/13/2014. Diagnoses include shoulder derangement, carpal tunnel syndrome, lumbar radiculopathy, and internal derangement of knee. Treatment has included analgesic medications, chiropractic manipulative therapy, and physical therapy. The reports from the initial treating physician in 2014 reflect treatment with 6 visits of physical therapy with strengthening, medications, and modified work. The subsequent treating physician reports beginning on 8/14/14 repeat much of the same information from report to report, and authorization is repeatedly requested for the same items, including those now under Independent Medical Review. Reports of the current primary treating physician began with an evaluation on 8/14/14. At that time there was ongoing, multifocal pain that had been treated by other physicians. The details of care were not mentioned. Physical therapy had been provided and was not beneficial. Shoulder range of motion was limited bilaterally and equally. Impingement was present. Median nerve sensory deficits were present in the hands. Tinsel's signs were positive in the wrists. Lumbar range of motion was full and there were no radicular deficits. Sensory deficits were present in the feet. The knees were tender with positive McMurray's signs. The treatment plan included an internist referral for internal issues, chiropractic care x12, EMG/NCS of the upper extremities, MRI of the shoulder, back, and knees, medications, and modified work. Per the PR2 of 09/11/2014 there was low back pain, shoulder pain, and knee pain. There were paresthesia in the right hand and foot. An EMG was to be performed to determine the pathology. Shoulder range of motion was limited bilaterally and

equally. Impingement was present. Median nerve sensory deficits were present in the hands. Tinsel's signs were positive in the wrists. Lumbar range of motion was full and there were no radicular deficits. Sensory deficits were present in the feet. The knees were tender with positive McMurray's signs. The treatment plan included diagnostic tests, chiropractic care, internist evaluation, medications, and modified work. Per the PR2 of 11/13/2014, there was no improvement. Chiropractic provided temporary relief. No physical therapy had been attended yet. Physical therapy was prescribed to strengthen the low back. Medications allowed him to function. Shoulder range of motion was limited bilaterally and equally. Impingement was present. Median nerve sensory deficits were present in the hands. Tinsel's signs were positive in the wrists. Lumbar range of motion was full and there were no radicular deficits. Sensory deficits were present in the feet. The knees were tender with positive McMurray's signs. The treatment plan included the same medications, physical therapy, diagnostic studies, and regular work status was reported to be usual work as of 12/15/14. On 11/21/2014 Utilization Review certified one of 12 requested chiropractic visits for the lower back and two of the 12 physical therapy visits. The EMG/NCS of the lower and upper extremities, omeprazole, Internal Medicine consultation, MRI of the knees, MRI of the shoulders, and MRI of the low back were non-certified. The MTUS was cited in support of the decision. Naproxen and hydrocodone were certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic care three times a week for four weeks, twelve total for the lower back:

Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58-60.

Decision rationale: Per the MTUS for Chronic Pain, a trial of 6 visits of manual therapy and manipulation may be provided over 2 weeks, with any further manual therapy contingent upon functional improvement. Given that the focus of manipulative therapy is functional improvement, function (including work status or equivalent) must be addressed as a starting point for therapy. A description of current function with functional goals was not included in the reports. 12 visits exceed the recommended initial course per the MTUS. No manual and manipulative therapy is medically necessary based on the lack of emphasis on functional restoration and a prescription which exceeds that recommended in the MTUS.

EMG/NCS bilateral lower and upper extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints Page(s): 182,303, 309.

Decision rationale: There are no reports from the prescribing physician which adequately describe neurologic findings that necessitate electrodiagnostic testing. Non-specific pain or paresthesias are not an adequate basis for performance of EMG or NCV. Medical necessity for electrodiagnostic testing is established by a clinical presentation with a sufficient degree of neurologic signs and symptoms to warrant such tests. Non-specific, non-dermatomal extremity symptoms are not sufficient alone to justify electrodiagnostic testing. The treating physician has not provided a sufficient clinical history and a description of specific neurological symptoms. Based on the available clinical information, the only neurologic abnormalities were median sensory deficits and non-specific sensory deficits in the feet. Additional information would be required to determine medical necessity for electrodiagnostic testing, such as duration of symptoms, nature of symptoms, prior treatment, review of other medical conditions, and necessity of EMG vs NCV. None of this kind of information was provided. EMG is only required for assessment of radiculopathy, and evidence for this condition was not presented. Based on the current clinical information, electrodiagnostic testing is not medically necessary, as the treating physician has not provided the specific indications, medical history, and clinical examination outlined in the MTUS.

MRI of the bilateral shoulders: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 214.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-209,200.

Decision rationale: The MTUS-ACOEM Guidelines, pages 207-9, discuss the criteria for imaging of the shoulder. Special studies are not needed unless there has been a 4-6 week period of conservative care. Exceptions to this rule include the specific bony pathology listed on page 207, and neurovascular compression. Page 200 of the ACOEM Guidelines describes the components of the clinical evaluation of the shoulder. The necessary components of the shoulder examination described in the MTUS are not present. The available reports do not adequately explain the kinds of conservative care already performed. The injured worker currently has non-specific, regional pain, which is not a good basis for performing an MRI. The treating physician has not provided sufficient evidence in support of likely intra-articular pathology or the other conditions listed in the MTUS. The MRIs are not medically necessary based on the MTUS recommendations.

MRI of the low back: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 304.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303, 290. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back chapter, MRI.

Decision rationale: The treating physician has not described the clinical evidence of significant pathology discussed in the MTUS, such as unequivocal objective findings that identify specific nerve compromise on the neurologic examination. No red flag conditions are identified. The treating physician has not provided an adequate clinical evaluation, as outlined in the MTUS ACOEM Guidelines Pages 291-296. Per the Official Disability Guidelines citation above, imaging for low back pain is not beneficial in the absence of specific signs of serious pathology. The treating physician has not provided specific indications for performing an MRI. MRI of the lumbar spine is not indicated in light of the paucity of clinical findings suggesting any serious pathology; increased or ongoing pain, with or without radiation, is not in itself indication for MRI. An MRI of the lumbar spine is not medically necessary based on lack of sufficient indications per the MTUS and the Official Disability Guidelines.

MRI of bilateral knees: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 335.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 332-335, 341, 343, 344-345, 347.

Decision rationale: Per the ACOEM Guidelines Page 341, special studies are not needed to evaluate most knee conditions until after a period of conservative care and observation. Page 343 lists surgical indications: activity limitation for more than one month, failure of an exercise program. Pages 344-5 discuss focal pathology amenable to surgery. Page 347 lists the clinical findings which indicate the need for surgery. In this case the question would be whether there is a realistic possibility of significant intra-articular pathology and need for surgery after a failure of conservative care. The available reports do not adequately explain the kinds of conservative care already performed. The necessary components of the knee exam are not present, see pages 332-335 of the ACOEM Guidelines. There is no evidence of a period of conservative care prior to prescribing the MRI, and the necessary components of the examination are not provided. The treating physician has not discussed the specific indications for the MRIs. The MRIs are not medically necessary based on the MTUS and lack of specific indications.

Physical Therapy three times a week for four weeks, twelve total for shoulders, knees, and wrist: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Introduction, functional improvement; Physical Medicine Page(s): 98-99, 9.

Decision rationale: The treating physician has not provided an adequate prescription, which must contain diagnosis, duration, frequency, and treatment modalities, at minimum. Per the MTUS, Chronic Pain section, functional improvement is the goal rather than the elimination of

pain. The maximum recommended quantity of Physical Medicine visits is 10, with progression to home exercise. The treating physician has stated that the current physical therapy prescription is for strengthening the back. He did not comment on the content of the prior physical therapy, and that it included back strengthening. It is not clear what is intended to be accomplished with this proposed physical therapy, given that it will not cure chronic pain and there are no other goals of therapy. The current physical therapy prescription exceeds the quantity recommended in the MTUS (maximum of 10 visits). No medical reports identify specific functional deficits, or functional expectations for further Physical Medicine. The Physical Medicine prescription is not sufficiently specific, and does not adequately focus on functional improvement. Given the completely non-specific prescription for physical therapy in this case, it is presumed that the therapy include passive modalities. Note that the MTUS recommends against passive modalities for chronic pain. Additional Physical Medicine is not medically necessary based on the MTUS, lack of a sufficient prescription, and lack of sufficient emphasis on functional improvement.

Internal Medicine consultation: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 92.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation A specific guideline cannot be cited because the requested service was not described in sufficient detail. In order to select the relevant guideline, the requested service must refer to a specific treatment, test, or referral. The request in this case was too generic and might conceivably refer to any number of medical conditions and guideline citations.

Decision rationale: The request to Independent Medical Review is for a referral which was not adequately explained. The treating physician did not supply sufficient information regarding the nature of the request and its indications. No internal medicine conditions requiring evaluation were discussed. The purpose of the referral is not clear. The request is therefore not medically necessary based on the lack of sufficient indications and lack of sufficient clinical evaluation.