

Case Number:	CM15-0133930		
Date Assigned:	07/22/2015	Date of Injury:	01/11/2012
Decision Date:	09/02/2015	UR Denial Date:	06/18/2015
Priority:	Standard	Application Received:	07/10/2015

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: California
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 59 year old female, who sustained an industrial injury on January 11, 2012. The injured worker was diagnosed as having unspecified musculoskeletal disorders and symptoms referable to the neck, other unspecified back disorder, lumbago, thoracic or lumbosacral neuritis or radiculitis, unspecified disorders of the bursae and tendons in shoulder region, carpal tunnel syndrome, derangement of meniscus not elsewhere classified and rotator cuff strain/sprain. Treatment to date has included physical therapy, acupuncture and medication. A progress note dated April 6, 2015 provides the injured worker complains of neck pain, shoulder pain, back pain and knee pain. She rates the pain 5/10 and reports physical therapy and acupuncture have helped. Physical exam notes cervical tenderness with decreased range of motion (ROM). Phalen's Tinel's and Finkelstein's test are positive with right shoulder impingement and decreased range of motion (ROM). There is thoracic tenderness with decreased range of motion (ROM) and straight leg raise is positive. McMurray's and Apley's are positive and there is tenderness of the left foot and ankle. There is a request for cervical and lumbar physical therapy, magnetic resonance imaging (MRI) and x-rays.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy 3 times a week for 4 weeks to the cervical spine: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58-60 of 127.

Decision rationale: The request is for physical therapy to aid in pain relief. The MTUS guidelines states that manipulation is recommended for chronic pain if caused by musculoskeletal conditions. Manual Therapy is widely used in the treatment of musculoskeletal pain. The intended goal or effect of Manual Medicine is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. Manipulation is manual therapy that moves a joint beyond the physiologic range-of-motion but not beyond the anatomic range-of-motion. It is indicated for low back pain but not ankle and foot conditions, carpal tunnel syndrome, forearm/wrist/hand pain, or knee pain. The use of active treatment modalities instead of passive treatments is associated with substantially better clinical outcomes. (Fritz, 2007) Active treatments also allow for fading of treatment frequency along with active self-directed home PT, so that less visits would be required in uncomplicated cases. In this case, the patient would benefit most from at home active therapy. As such, the request is not medically necessary.

Physical therapy 3 times a week for 4 weeks to the lumbar spine: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58-60 of 127.

Decision rationale: The request is for physical therapy to aid in pain relief. The MTUS guidelines states that manipulation is recommended for chronic pain if caused by musculoskeletal conditions. Manual Therapy is widely used in the treatment of musculoskeletal pain. The intended goal or effect of Manual Medicine is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. Manipulation is manual therapy that moves a joint beyond the physiologic range-of-motion but not beyond the anatomic range-of-motion. It is indicated for low back pain but not ankle and foot conditions, carpal tunnel syndrome, forearm/wrist/hand pain, or knee pain. The use of active treatment modalities instead of passive treatments is associated with substantially better clinical outcomes. (Fritz, 2007) Active treatments also allow for fading of treatment frequency along with active self-directed home PT, so that less visits would be required in uncomplicated cases. In this case, the patient would benefit most from at home active therapy. As such, the request is not medically necessary.

MRI of the right shoulder without contrast: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: The request is for an MRI of the shoulder. The ODG guidelines state the following regarding this topic: Recommended as indicated below. Magnetic resonance imaging (MRI) and arthrography have fairly similar diagnostic and therapeutic impact and comparable accuracy, although MRI is more sensitive and less specific. Magnetic resonance imaging may be the preferred investigation because of its better demonstration of soft tissue anatomy. (Banchard, 1999) Subtle tears that are full thickness are best imaged by MR arthrography, whereas larger tears and partial-thickness tears are best defined by MRI, or possibly arthrography, performed with admixed gadolinium, which if negative, is followed by MRI. (Oh, 1999) The results of a recent review suggest that clinical examination by specialists can rule out the presence of a rotator cuff tear, and that either MRI or ultrasound could equally be used for detection of full-thickness rotator cuff tears. (Dinnes, 2003) Shoulder arthrography is still the imaging "gold standard" as it applies to full-thickness rotator cuff tears, with over 99% accuracy, but this technique is difficult to learn, so it is not always recommended. Magnetic resonance of the shoulder and specifically of the rotator cuff is most commonly used, where many manifestations of a normal and an abnormal cuff can be demonstrated. The question we need to ask is: Do we need all this information? If only full-thickness cuff tears require an operative procedure and all other abnormalities of the soft tissues require arthroscopy, then would shoulder arthrography suffice? (Newberg, 2000) Ultrasonography and magnetic resonance imaging have comparable high accuracy for identifying biceps pathologies and rotator cuff tears, and clinical tests have modest accuracy in both disorders. The choice of which imaging test to perform should be based on the patient's clinical information, cost, and imaging experience of the radiology department. (Ardic, 2006) MRI is the most useful technique for evaluation of shoulder pain due to subacromial impingement and rotator cuff disease and can be used to diagnose bursal inflammatory change, structural causes of impingement and secondary tendinopathy, and partial- and full-thickness rotator cuff tears. However, the overall prevalence of tears of the rotator cuff on MRI is 34% among symptom-free patients of all age groups, being 15% for full-thickness tears and 20% for partial-thickness tears. The results of this study support the use of MRI of the shoulder before injection both to confirm the diagnosis and to triage affected patients to those likely to benefit (those without a cuff tear) and those not likely to benefit (those with a cuff tear). (Hambly, 2007) The preferred imaging modality for patients with suspected rotator cuff disorders is MRI. However, ultrasonography may emerge as a cost-effective alternative to MRI. (Burbank, 2008) Primary care physicians are making a significant amount of inappropriate referrals for CT and MRI, according to new research published in the Journal of the American College of Radiology. There were high rates of inappropriate examinations for shoulder MRIs (37%), shoulder MRI in patients with no histories of trauma and documented osteoarthritis on plain-film radiography. (Lehnert, 2010) Non-contrast MRI is sufficient for rotator cuff tears, and contrast enhancement is recommended for SLAP tears. In the past when MRI images and sensitivity were poor, the additional injection of contrast into the shoulder improved interpretation. This is not necessary with modern high field machines. (Spencer, 2013) (Farshad-

Amacker, 2013) (Arnold, 2012) Intraarticular contrast material is helpful in diagnosing labral tears in the shoulder, particularly tears of the anterior labrum. (Major, 2011) See also MR arthrogram. Indications for imaging -- Magnetic resonance imaging (MRI): Acute shoulder trauma, suspect rotator cuff tear/impingement; over age 40; normal plain radiographs, Subacute shoulder pain, suspect instability/labral tear, Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. (Mays, 2008) In this case, there is inadequate documentation of a qualifying history or physical exam finding justifying an MRI. There are no reports of acute injury or a sudden change in physical exam findings. Pending the receipt of further records explaining the reasoning for the study, the request is not medically necessary.

X-ray of the right wrist 3 views: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) x-rays wrist/hand radiography.

Decision rationale: The request is for the x-rays of the wrist. The ODG guidelines state the following regarding the topic: Recommended as indicated below. For most patients with known or suspected trauma of the hand, wrist, or both, the conventional radiographic survey provides adequate diagnostic information and guidance to the surgeon. However, in one large study, wrist fractures, especially those of the distal radius and scaphoid, accounted for more delayed diagnoses than any other traumatized region in patients with initial normal emergency room radiographs. Thus, when initial radiographs are equivocal, or in the presence of certain clinical or radiographic findings, further imaging is appropriate. This may be as simple as an expanded series of special views or fluoroscopic spot films; or may include tomography, arthrography, bone scintigraphy, computed tomography (CT), or magnetic resonance (MR) imaging. (ACR, 2001) (Dalinka, 2000) For inflammatory arthritis, high-resolution in-office MRI with an average follow-up of 8 months detects changes in bony disease better than radiography, which is insensitive for detecting changes in bone erosions for this patient population in this time frame. (Chen, 2006) Standard x-rays are the first step in sports injuries. Although arthrography is still the reference for the diagnosis of intrinsic ligament and cartilaginous lesions, MRI can sometimes be sufficient. Ultrasonography is a dynamic process and is accurate in detecting tendon injuries. See also MRI, Ultrasound and X-rays. See also ACR Appropriateness Criteria. Indications for imaging -- X-rays: Acute hand or wrist trauma, wrist trauma, first exam, Acute hand or wrist trauma, suspect acute scaphoid fracture, first exam, plus cast and repeat radiographs in 10-14 days, Acute hand or wrist trauma, suspect distal radioulnar joint subluxation, Acute hand or wrist trauma, suspect hook of the hamate fracture, Acute hand or wrist trauma, suspect metacarpal fracture or dislocation, Acute hand or wrist trauma, suspect phalangeal fracture or dislocation, Acute hand or wrist trauma, suspect thumb fracture or dislocation, Acute hand or wrist trauma, suspect gamekeeper injury (thumb MCP ulnar collateral ligament injury), Chronic wrist pain, first study obtained in patients with chronic wrist pain with or without prior injury, no specific area of pain specified. In this case, there is documentation of one of the indications listed above to justify x-rays. The patient had a previous wrist injury with scaphoid-lunate ligament repair. Ongoing pain is described and an x-ray is requested for evaluation of healing. As such, the request is medically necessary.

