

Case Number:	CM15-0186403		
Date Assigned:	09/28/2015	Date of Injury:	06/10/2013
Decision Date:	11/25/2015	UR Denial Date:	09/09/2015
Priority:	Standard	Application Received:	09/22/2015

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: Physical Medicine & Rehabilitation, Pain Management

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This is a 62 year old male with a date of injury on 6-10-2013. A review of the medical records indicates that the injured worker is undergoing treatment for right shoulder internal derangement and right knee internal derangement. According to the progress report dated 8-25-2015, the injured worker complained of frequent right knee pain. He complained of intermittent right shoulder pain associated with numbness. He reported intermittent occipital headaches. Per the treating physician (8-25-2015), the injured worker was not currently working. Work status was noted to be partially disabled. The physical exam (8-25-2015) revealed the injured worker to walk with a limp favoring the right leg. He was unable to squat due to pain. Exam of the right shoulder revealed tenderness. Neer's and Hawkins-Kennedy tests were positive. Range of motion was restricted due to pain. Exam of the right knee revealed tenderness over the medial and lateral joint lines. McMurray's test was positive. Range of motion was normal but painful. Treatment has included right shoulder rotator cuff repair (12-16-2013) with post-operative physical therapy and medications (what med since at least what date). The injured worker underwent magnetic resonance imaging (MRI) of the right knee on 10-5-2014. The original Utilization Review (UR) (9-9-2015) denied requests for magnetic resonance imaging (MRI) arthrogram of the right shoulder and right knee, physical therapy for the right shoulder and right knee, x-ray of the right knee and chiropractic care for the right knee. UR modified a request for chiropractic care for the right shoulder from 12 visits to 9 visits.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI arthrogram of the right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, MR arthrogram.

Decision rationale: With regard to the request for MR arthrogram of the shoulder, the ACOEM guidelines state the following: "Routine testing (laboratory tests, plain-film radiographs of the shoulder) and more specialized imaging studies are not recommended during the first month to six weeks of activity limitation due to shoulder symptoms, except when a red flag noted on history or examination raises suspicion of a serious shoulder condition or referred pain. Cases of impingement syndrome are managed the same regardless of whether radiographs show calcium in the rotator cuff or degenerative changes are seen in or around the glenohumeral joint or AC joint. Suspected acute tears of the rotator cuff in young workers may be surgically repaired acutely to restore function; in older workers, these tears are typically treated conservatively at first. Partial-thickness tears should be treated the same as impingement syndrome regardless of magnetic resonance imaging (MRI) findings." Furthermore, the ODG is cited which specify that MR arthrogram of the shoulder can be very sensitive for detection of labral pathology. In the case of this injured worker, the worker has previously undergone arthroscopic subacromial decompression of the shoulder and continues with pain. A progress note on August 25, 2015 documents the requesting providers request for this imaging, but no specifics are supplied. Rather there was a general quotation of relevant guidelines. It is noted that the patient has under prior shoulder imaging on 10/7/2013 which demonstrated the subscapularis full thickness tear. Since then on 12/16/13, the patient had subacromial decompression, biceps tenodesis, and rotator cuff repair. There is no clear delineation of recent conservative treatment or notation of concern for labral pathology that would warrant repeat MRI at this juncture. This request is not medically necessary.

Chiropractic care 3 times a week for 4 weeks for the right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation ODG Chiropractic Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Manual therapy & manipulation.

Decision rationale: Regarding the request for chiropractic care, the Chronic Pain Medical Treatment Guidelines state on pages 58-60 the following regarding manual therapy & manipulation: 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. Low back: Recommended as an option. Therapeutic care - Trial of 6 visits over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks. Elective/maintenance care - Not medically necessary. Recurrences/flare-ups - Need to re-evaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months. Ankle & Foot: Not recommended. Carpal tunnel syndrome: Not recommended. Forearm, Wrist, & Hand: Not recommended. Knee: Not recommended. Treatment Parameters from state guidelines a. Time to produce effect: 4 to 6 treatments b. Frequency: 1 to 2 times per week the first 2 weeks, as indicated by the severity of the condition. Treatment may continue at 1 treatment per week for the next 6 weeks. c. Maximum duration: 8 weeks. At week 8, patients should be reevaluated. Care beyond 8 weeks may be indicated for certain chronic pain patients in whom manipulation is helpful in improving function, decreasing pain and improving quality of life. In these cases, treatment may be continued at 1 treatment every other week until the patient has reached plateau and maintenance treatments have been determined. In the case of this injured worker, there is no comprehensive summary of chiropractic to date or functional benefit from prior chiropractic treatment for the shoulder region. If this is an initial request, then it exceeds guideline recommendation which specify for an initial trial of up to 6 visits. Given these factors, this request is not medically necessary.

Physical therapy 3 times a week for 4 weeks for the right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Manipulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

Decision rationale: In the case of this injured worker, the submitted documentation failed to indicate functional improvement from previous physical therapy. This functional improvement can include a reduction in work restrictions or other clinically significant improved function in activities of daily living. According to the Chronic Pain Medical Treatment Guidelines, continuation of physical therapy is contingent on demonstration of functional improvement from previous physical therapy. There is no comprehensive summary of how many sessions have been attended in total over the course of this injury, and what functional benefit the worker gained from PT. Therefore, additional physical therapy is not medically necessary.

MRI arthrogram of the right knee: Upheld

Claims Administrator guideline: Decision based on MTUS Knee Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Knee Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg Chapter, MRI and MR Arthrography Topic.

Decision rationale: Regarding the request for MR arthrogram of the knee, ACOEM indicate that most knee problems improve quickly once any red flag issues are ruled out. They go on to indicate that MRIs are superior to arthrography for both diagnosis and safety reasons. More detailed recommendations are found in the ODG, which states that arthrography is recommended as a postoperative option to help diagnose a suspected residual or recurrent tear. "Recommended as a postoperative option to help diagnose a suspected residual or recurrent tear, for meniscal repair or for meniscal resection of more than 25%. In this study, for all patients who underwent meniscal repair, MR arthrography was required to diagnose a residual or recurrent tear. In patients with meniscal resection of more than 25% who did not have severe degenerative arthrosis, avascular necrosis, chondral injuries, native joint fluid that extends into a meniscus, or a tear in a new area, MR arthrography was useful in the diagnosis of residual or recurrent tear. Patients with less than 25% meniscal resection did not need MR arthrography. (Magee, 2003)" Within the documentation available for review, there is documentation that the patient has previously undergone surgical intervention for the knee in 2004. An MRI performed since the time of the surgery, on 10/5/2014, documented medial meniscal tear. An x-ray of the right knee on 8/28/14 demonstrated degenerative enthesopathy of the upper patellar pole and also osteophytes. It is unclear what worsening in pathology has taken place since the timing of prior imaging. In the absence of such documentation, the currently requested arthrogram of the knee is not medically necessary.

Standing X-rays of the right knee including AP, lateral and sunrise views: Upheld

Claims Administrator guideline: Decision based on MTUS Knee Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Knee Complaints 2004, Section(s): special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg Chapter, Radiographs.

Decision rationale: Regarding the request for repeat x-ray of the knee, ACOEM guidelines state that special studies are not needed to evaluate most knee complaints until after a period of conservative care and observation. They support the use of x-rays for joint diffusion within 24 hours of trauma, palpable tenderness over the fibular head or patella, inability to walk 4 steps or bear weight immediately within a week of trauma, and inability to flex the knee to 90. ODG contains criteria for x-ray of the knee in the presence of non-traumatic knee pain with patellofemoral pain or nonspecific pain. Within the documentation available for review, there is documentation that the patient has previously undergone surgical intervention for the knee in 2004. An MRI performed since the time of the surgery, on 10/5/2014, documented medial meniscal tear. An x-ray of the right knee on 8/28/14 demonstrated degenerative enthesopathy of the upper patellar pole and also osteophytes. It is unclear what worsening in pathology or symptoms has taken place since the timing of prior imaging. In the absence of such documentation, the currently requested standing x-rays of the right knee including AP, lateral and sunrise views is not medically necessary.

Chiropractic care 3x4 weeks for the right knee: Upheld

Claims Administrator guideline: Decision based on MTUS Knee Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Manual therapy & manipulation.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state on pages 58-60 the following regarding manual therapy & manipulation: 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. Low back: Recommended as an option. Therapeutic care - Trial of 6 visits over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks. Elective/maintenance care - Not medically necessary. Recurrences/flare-ups - Need to re-evaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months. Ankle & Foot: Not recommended. Carpal tunnel syndrome: Not recommended. Forearm, Wrist, & Hand: Not recommended. Knee: Not recommended. Treatment Parameters from state guidelines: a. Time to produce effect: 4 to 6 treatments b. Frequency: 1 to 2 times per week the first 2 weeks, as indicated by the severity of the condition. Treatment may continue at 1 treatment per week for the next 6 weeks. c. Maximum duration: 8 weeks. At week 8, patients should be reevaluated. Care beyond 8 weeks may be indicated for certain chronic pain patients in whom manipulation is helpful in improving function, decreasing pain and improving quality of life. In these cases, treatment may be continued at 1 treatment every other week until the patient has reached plateau and maintenance treatments have been determined. Given that the guidelines above specifically state that manipulation in the knee region is not recommended, this request is not medically necessary.

Physical therapy 3x4 weeks for the right knee: Upheld

Claims Administrator guideline: Decision based on MTUS Knee Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

Decision rationale: In the case of this injured worker, the submitted documentation failed to indicate functional improvement from previous physical therapy. This functional improvement can include a reduction in work restrictions or other clinically significant improved function in activities of daily living. According to the Chronic Pain Medical Treatment Guidelines, continuation of physical therapy is contingent on demonstration of functional improvement from previous physical therapy. There is no comprehensive summary of how many sessions have been attended in total over the course of this injury, and what functional benefit the worker gained from PT. It should be further noted that the patient's surgical intervention for the right knee was years ago and this is not considered a post-operative request for PT given the time frame. Therefore, additional physical therapy is not medically necessary.