

Case Number:	CM15-0193644		
Date Assigned:	10/08/2015	Date of Injury:	09/26/2011
Decision Date:	12/14/2015	UR Denial Date:	09/04/2015
Priority:	Standard	Application Received:	10/01/2015

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:

The injured worker is a 49 year old female, who sustained an industrial injury on 9-26-11. The injured worker is being treated for cervical sprain, derangement of joint (bilateral shoulder), lumbar sprain-strain, internal derangement of bilateral knee joint and foot contusion. (MRI) magnetic resonance imaging of bilateral knees and lumbar spine were performed 12-24-11. Treatment to date has included joint injections, physical therapy (over a year prior), oral medications including Ketoprofen 200mg and Omeprazole 20mg. On 8-20-15, the injured worker complains of pain in bilateral shoulders, pain in hands with numbness and tingling, pain in knees and feet, worsening low back pain with radiation to bilateral lower extremities, pain in cervical spine and worsening headaches. She is temporarily totally disabled. Physical exam performed on 8-20-15 and 8-27-15 revealed spasm in cervical paraspinal muscles with tenderness to palpation of the paraspinal muscles and restricted cervical range of motion; tenderness to pressure over bilateral biceps tendons and trapezius muscles with restricted range of motion of bilateral shoulders and positive impingement sign bilaterally; and spasm present in lumbar paraspinal muscles with tenderness to palpation of lumbar paraspinal muscles and restricted range of motion; tenderness is also noted over bilateral medial knees. The treatment plan included physical therapy 12 sessions for neck, low back, shoulders and knees; (EMG) Electromyogram-(NCV) Nerve Condition Velocity studies of bilateral upper and lower extremities and (MRI) magnetic resonance imaging of neck, shoulders, low back and knees. On 9-4-15 request for physical therapy 12 sessions for neck, low back, shoulders and knees; (EMG) Electromyogram-(NCV) Nerve Condition Velocity studies of bilateral upper and lower

extremities and (MRI) magnetic resonance imaging of neck, shoulders, low back and knees was non-certified by utilization review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy x 12 for the cervical spine and bilateral shoulders: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck & Upper Back Chapter, Physical Therapy Shoulder Complaints Chapter, Physical Therapy.

Decision rationale: Regarding the request for additional physical therapy, Chronic Pain Medical Treatment Guidelines recommend a short course of active therapy with continuation of active therapies at home as an extension of the treatment process in order to maintain improvement levels. ODG has more specific criteria for the ongoing use of physical therapy. ODG recommends a trial of physical therapy. If the trial of physical therapy results in objective functional improvement, as well as ongoing objective treatment goals, then additional therapy may be considered. Within the documentation available for review, there is documentation of completion of prior PT sessions, but there is no documentation of specific objective functional improvement with the previous sessions and remaining deficits that cannot be addressed within the context of an independent home exercise program, yet are expected to improve with formal supervised therapy. Furthermore, the request exceeds the amount of PT recommended by the CA MTUS and, unfortunately, there is no provision for modification of the current request. In light of the above issues, the currently requested additional physical therapy is not medically necessary.

MRI of the left 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, Magnetic resonance imaging (MRI).

Decision rationale: Regarding the request for MRI of the left shoulder, ACOEM Guidelines state that more specialized imaging studies are not recommended during the 4 to 6 weeks of activity limitation due to shoulder symptoms except when a red flag is noted on history or examination. Cases of impingement syndrome are managed the same whether or not radiographs show calcium in the rotator cuff or degenerative changes are seen in or around the glenohumeral joint or AC joint. Guidelines further specify imaging studies for physiologic evidence of tissue insult or neurovascular dysfunction, failure to progress in a strengthening program intended to

avoid surgery, and clarification of the anatomy prior to an invasive procedure. ODG recommends MRI of the shoulder for subacute shoulder pain with suspicion of instability/labral tear or following acute shoulder trauma with suspicion of rotator cuff tear/impingement with normal plain film radiographs. Within the documentation available for review, there is no clear documentation of what failed conservative treatment options have been provided for this body region to date. The physical examination of the submitted notes does not document any red flag symptoms which would warrant MRI. Furthermore, it is unclear how an MRI will change the patient's current treatment plan. Given this, the currently requested left shoulder MRI is not medically necessary.

MRI of the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, MRI Topic.

Decision rationale: Regarding the request for repeat lumbar MRI, ACOEM Practice Guidelines do not have specific guidelines on when a repeat study is warranted. In general, lumbar MRI is recommended when there are unequivocal objective findings that identify specific nerve compromise on the neurologic examination in patients who do not respond to treatment and would consider surgery an option. The Official Disability Guidelines state that repeat MRIs should be reserved for cases in which a significant change in pathology has occurred. Within the documentation available for review, there is identification of L5-S1 nerve compromise on the neurologic exam. However, there is no statement indicating what medical decision-making will be based upon the outcome of the currently requested MRI. Furthermore, there is no documentation indicating how the patient's subjective complaints and objective findings have changed since the time of the most recent MRI of the lumbar spine. In the absence of clarity regarding those issues, the currently requested repeat lumbar MRI is not medically necessary.

EMG/NCS of the bilateral upper extremities: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Electrodiagnostic Testing.

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck Chapter, Electrodiagnostic Studies, Electromyography, Nerve Conduction Studies.

Decision rationale: Regarding the request for EMG/NCS of the upper extremities, ACOEM Practice Guidelines state that the electromyography and nerve conduction velocities including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. The nerve conduction component of

an electrodiagnostic study measures the amplitude, conduction velocity, waveform, and latency of sensory and motor nerves. Within the documentation available for review, the only neurological finding on exam is suggestive of carpal tunnel syndrome as the patient has reduced sensation in the bilateral median nerve distribution and positive Tinel's sign bilaterally. Furthermore, neural tension signs such as Spurling's maneuver are noted to be negative bilaterally. Given this, the currently request is not medically necessary.

EMG/NCS of the bilateral lower extremities: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Electrodiagnostic Testing.

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

Decision rationale: With regard to EMG/NCS of the lower extremities to evaluate for lumbar radiculopathy, Section 9792.23.5 of the California Code of Regulations, Title 8, page 6 adopts ACOEM Practice Guidelines Chapter 12. ACOEM Chapter 12 on page 303 states: Electromyography (EMG), including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks. The update to ACOEM Chapter 12 Low Back Disorders on pages 60-61 further states: The nerve conduction studies are usually normal in radiculopathy (except for motor nerve amplitude loss in muscles innervated by the involved nerve root in more severe radiculopathy and H-wave studies for unilateral S1 radiculopathy). Nerve conduction studies rule out other causes for lower limb symptoms (generalized peripheral neuropathy, peroneal compression neuropathy at the proximal fibular, etc.) that can mimic sciatica. Further guidelines can be found in the Official Disability Guidelines. The Official Disability Guidelines Low Back Chapter, states the following regarding electromyography: Recommended as an option (needle, not surface). EMGs (electromyography) may be useful to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMGs are not necessary if radiculopathy is already clinically obvious. (Bigos. 1999) (Ortiz-Corredor. 2003) (Haig. 2005) EMGs may be required by the AMA Guides for an impairment rating of radiculopathy. (AMA 2001) With regard to nerve conduction studies, the Official Disability Guidelines Low Back Chapter states: Nerve conduction studies (NCS) section: Not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. (Utah. 2006) However, it should be noted that this guideline has lower precedence than the ACOEM Practice Guidelines which are incorporated into the California Medical Treatment and Utilization Schedule, which do recommend NCS. Therefore, nerve conduction studies are recommended in evaluations for lumbar radiculopathy. Within the documentation available for review, there is exam findings of bilateral positive straight leg raise and reduced sensations in bilateral L5-S1 dermatome to support a diagnosis of nerve compromise. Given this, the current request is medically necessary.

Physical therapy x 12 for the bilateral upper extremities: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist, and Hand Chapter, Physical Therapy.

Decision rationale: Regarding the request for additional physical therapy, Chronic Pain Medical Treatment Guidelines recommend a short course of active therapy with continuation of active therapies at home as an extension of the treatment process in order to maintain improvement levels. ODG has more specific criteria for the ongoing use of physical therapy. ODG recommends a trial of physical therapy. If the trial of physical therapy results in objective functional improvement, as well as ongoing objective treatment goals, then additional therapy may be considered. Within the documentation available for review, there is documentation of completion of prior PT sessions, but there is no documentation of specific objective functional improvement with the previous sessions and remaining deficits that cannot be addressed within the context of an independent home exercise program, yet are expected to improve with formal supervised therapy. Furthermore, the request exceeds the amount of PT recommended by the CA MTUS and, unfortunately, there is no provision for modification of the current request. In light of the above issues, the currently requested additional physical therapy is not medically necessary.

MRI 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, Magnetic resonance imaging (MRI).

Decision rationale: Regarding the request for MRI of the right shoulder, ACOEM Guidelines state that more specialized imaging studies are not recommended during the 4 to 6 weeks of activity limitation due to shoulder symptoms except when a red flag is noted on history or examination. Cases of impingement syndrome are managed the same whether or not radiographs show calcium in the rotator cuff or degenerative changes are seen in or around the glenohumeral joint or AC joint. Guidelines further specify imaging studies for physiologic evidence of tissue insult or neurovascular dysfunction, failure to progress in a strengthening program intended to avoid surgery, and clarification of the anatomy prior to an invasive procedure. ODG recommends MRI of the shoulder for subacute shoulder pain with suspicion of instability/labral tear or following acute shoulder trauma with suspicion of rotator cuff tear/impingement with normal plain film radiographs. Within the documentation available for review, there is no clear documentation of what failed conservative treatment options have been provided for this body region to date. The physical examination of the submitted notes does not document any red flag symptoms which would warrant MRI. Furthermore, it is unclear how an MRI will change the patient's current treatment plan. Given this, the currently requested right shoulder MRI is not medically necessary.

MRI of the cervical spine: Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004.

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

Decision rationale: Regarding the request for cervical MRI, guidelines support the use of imaging for emergence of a red flag, physiologic evidence of tissue insult or neurologic deficit, failure to progress in a strengthening program intended to avoid surgery, and for clarification of the anatomy prior to an invasive procedure. Within the documentation available for review, there is no indication of any red flag diagnoses. Additionally, the only neurological finding on exam is suggestive of carpal tunnel syndrome as the patient has reduced sensation in the bilateral median nerve distribution and positive Tinel's sign bilaterally. There is a negative Spurling's maneuver bilaterally, and normal motor and reflexes on exam. Given this, the requested cervical MRI is not medically necessary.

Physical therapy x 12 for the low back: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Physical Therapy.

Decision rationale: Regarding the request for additional physical therapy, Chronic Pain Medical Treatment Guidelines recommend a short course of active therapy with continuation of active therapies at home as an extension of the treatment process in order to maintain improvement levels. ODG has more specific criteria for the ongoing use of physical therapy. ODG recommends a trial of physical therapy. If the trial of physical therapy results in objective functional improvement, as well as ongoing objective treatment goals, then additional therapy may be considered. Within the documentation available for review, there is documentation of completion of prior PT sessions, but there is no documentation of specific objective functional improvement with the previous sessions and remaining deficits that cannot be addressed within the context of an independent home exercise program, yet are expected to improve with formal supervised therapy. Furthermore, the request exceeds the amount of PT recommended by the CA MTUS and, unfortunately, there is no provision for modification of the current request. In light of the above issues, the currently requested additional physical therapy is not medically necessary.