

Case Number:	CM15-0222137		
Date Assigned:	11/17/2015	Date of Injury:	01/14/2010
Decision Date:	12/31/2015	UR Denial Date:	11/03/2015
Priority:	Standard	Application Received:	11/12/2015

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

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 41 year old female who sustained an industrial injury 01-14-10. A review of the medical records reveals the injured worker is undergoing treatment for multilevel disc disease with cervical and lumbar bulges, left cubital tunnel syndrome, right shoulder impingement syndrome, left gastrocnemius sprain-strain, and stress anxiety and depression. Medical records (10-01-15) reveal the injured worker complains of neck, bilateral shoulder, left knee, and left calf pain. The physical exam (10-01-15) reveals loss of range of motion of the cervical and lumbar spines. Loss of sensation was noted over the lateral arm and forearm. Decreased sensation was noted over the lateral lower leg as well as the dorsal foot. A "slight" loss of range of motion was noted in the left shoulder with a positive impingement sign. "Slight" decreased quadriceps strength of 4+/5 was noted on the left knee with tenderness over the medial joint lines. Tenderness was present over the gastrocnemius with palpation and swelling. Prior treatment includes KeraTek gel. The original utilization review (11-03-15) non certified the request for a MRI of the left calf, a psychiatric consultation, and 12 physical therapy sessions.

IMR ISSUES, DECISIONS AND RATIONALES

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

One (1) MRI of the left calf: 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) Knee and Leg chapter, under Magnetic resonance imaging.

Decision rationale: The patient presents on 09/29/15 with persistent pain in the neck, back, bilateral shoulders, left knee, and left calf. The patient's date of injury is 01/14/10. The request is for one (1) mri of the left calf. The RFA is dated 10/06/15. Physical examination dated 09/29/15 reveals reduced cervical range of motion, positive cervical compression test with pain radiation into the left upper extremity, loss of sensation along the left lateral arm/forearm, positive straight leg raise test on the left, decreased sensation in the left lower extremity and dorsal foot. The provider also notes reduced range of motion in the left shoulder, positive impingement test (trace), decreased left quadriceps muscle, tenderness to the medial joint line and gastrocnemius with 1+ swelling noted. The patient is currently prescribed Tramadol. Patient is currently working. ODG Guidelines, Knee and Leg chapter, under Magnetic resonance imaging states: Indications for imaging -- MRI- Acute trauma to the knee, including significant trauma , or if suspect posterior knee dislocation or ligament or cartilage disruption. Non- traumatic knee pain, child or adolescent: nonpatellofemoral symptoms. Initial anteroposterior and lateral radiographs non-diagnostic next study if clinically indicated. If additional study is needed. Non-traumatic knee pain, child or adult. Patellofemoral symptoms. Initial anteroposterior, lateral, and axial radiographs non-diagnostic. If additional imaging is necessary, and if internal derangement is suspected. Non-traumatic knee pain, adult. Non-trauma, non- tumor, non-localized pain. Initial anteroposterior and lateral radiographs non-diagnostic. Non- traumatic knee pain, adult - non-trauma, non-tumor, non-localized pain. Initial anteroposterior and lateral radiographs demonstrate evidence of internal derangement." In regard to the MRI of the left calf, the request is not appropriate. There is no evidence that this patient has had any MRI imaging of the calf to date but it is not known what more information an MRI would reveal. The patient already had an ultrasound of the calf which would have evaluated not only the vessels, but also any major muscles tears or anatomic abnormalities. The patient had an MRI of the knee as well. As for a possible significant tear of the gastrocnemius, a careful examination should be sufficient along with conservative care. A severe tear requiring surgical intervention should have been obvious to the examiner. There are no pertinent guidelines regarding MRI imaging of the calf, which would substantiate such imaging. Therefore, the request is not medically necessary.

One (1) psychiatric consultation: Overturned

Claims Administrator guideline: Decision based on MTUS Stress-Related Conditions 2004.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness and Stress Chapter, under Cognitive therapy for depression and Other Medical Treatment Guidelines MTUS/ACOEM, Independent Medical Examinations and Consultations, chapter 7, page 127.

Decision rationale: The patient presents on 09/29/15 with persistent pain in the neck, back, bilateral shoulders, left knee, and left calf. The patient's date of injury is 01/14/10. The request is for one (1) psychiatric consultation. The RFA is dated 10/06/15. Physical examination dated 09/29/15 reveals reduced cervical range of motion, positive cervical compression test with pain radiation into the left upper extremity, loss of sensation along the left lateral arm/forearm, positive straight leg raise test on the left, decreased sensation in the left lower extremity and dorsal foot. The provider also notes reduced range of motion in the left shoulder, positive impingement test (trace), decreased left quadriceps muscle, tenderness to the medial joint line and gastrocnemius with 1+ swelling noted. The patient is currently prescribed Tramadol. Patient is currently working. MTUS/ACOEM, Independent Medical Examinations and Consultations, chapter 7, page 127 states that 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. A referral may be for consultation 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." Official Disability Guidelines, Mental Illness and Stress Chapter, under Cognitive therapy for depression has the following: Recommended. Cognitive behavior therapy for depression is recommended based on meta-analyses that compare its use with pharmaceuticals. Cognitive behavior therapy fared as well as antidepressant medication with severely depressed outpatients in four major comparisons. Effects may be longer lasting (80% relapse rate with antidepressants versus 25% with psychotherapy). (Paykel, 2006) (Bockting, 2006) (DeRubeis, 1999) (Goldapple, 2004) It also fared well in a meta-analysis comparing 78 clinical trials from 1977 -1996. (Gloaguen, 1998) In another study, it was found that combined therapy (antidepressant plus psychotherapy) was found to be more effective than psychotherapy alone. (Thase, 1997) A recent high quality study concluded that a substantial number of adequately treated patients did not respond to antidepressant therapy. ODG Psychotherapy Guidelines: Up to 13-20 visits over 7-20 weeks (individual sessions), if progress is being made. (The provider should evaluate symptom improvement during the process, so treatment failures can be identified early and alternative treatment strategies can be pursued if appropriate.) In cases of severe Major Depression or PTSD, up to 50 sessions if progress is being made. In regard to this consultation with a psychiatrist for this patient's anxiety and depression, the request is appropriate. Progress note dated 09/29/15 indicates that the patient presents with depression and anxiety secondary to chronic pain/disability. There is no evidence of prior mental health consultation in the records provided. MTUS guidelines support psychiatric evaluation and treatment for chronic pain, and ACOEM guidelines indicate that providers are justified in seeking additional expertise in cases where the course of care could benefit from a specialist. Given this patient's continuing pain symptoms, anxiety, and depression, consultation with a mental health provider could produce significant benefits. Therefore, the request is medically necessary.

Twelve (12) physical therapy sessions: 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 rationale: The patient presents on 09/29/15 with persistent pain in the neck, back, bilateral shoulders, left knee, and left calf. The patient's date of injury is 01/14/10. The request is for twelve (12) physical therapy sessions. The RFA is dated 10/06/15. Physical examination dated 09/29/15 reveals reduced cervical range of motion, positive cervical compression test with pain radiation into the left upper extremity, loss of sensation along the left lateral arm/forearm, positive straight leg raise test on the left, decreased sensation in the left lower extremity and dorsal foot. The provider also notes reduced range of motion in the left shoulder, positive impingement test (trace), decreased left quadriceps muscle, tenderness to the medial joint line and gastrocnemius with 1+ swelling noted. The patient is currently prescribed Tramadol. Patient is currently working. MTUS Guidelines, Physical Medicine Section, pages 98, 99 has the following: "recommended as indicated below. Allow for fading of treatment frequency -from up to 3 visits per week to 1 or less-, plus active self-directed home Physical Medicine." MTUS guidelines pages 98, 99 states that for "Myalgia and myositis, 9-10 visits are recommended over 8 weeks. For Neuralgia, neuritis, and radiculitis, 8-10 visits are recommended." In regard to the 12 physical therapy sessions for this patient's chronic pain, the provider has exceeded guideline recommendations. There is no evidence in the records provided that this patient has completed any recent physical therapy treatments. For chronic pain complaints, MTUS guidelines support 8-10 physical therapy treatments. The request for 12 treatments in exceeds these guideline recommendations and cannot be substantiated. Therefore, the request is not medically necessary.