

Case Number:	CM15-0034431		
Date Assigned:	04/21/2015	Date of Injury:	10/10/2013
Decision Date:	08/10/2015	UR Denial Date:	01/28/2015
Priority:	Standard	Application Received:	02/24/2015

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: New York

Certification(s)/Specialty: Internal 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 53 year old female, who sustained an industrial injury on 10/10/2013. She reported injury to her bilateral knees and left hand after a trip and fall. The injured worker was diagnosed as having left partial rotator cuff tear, medial epicondylitis, elbow sprain/strain, ulnar nerve injury, and other specified sites of knee or leg. Treatment to date has included left shoulder injection, x-rays, and physical therapy (progress notes not included). Currently per the Doctor's First Report of Occupational Injury report (dated 1/06/2015), the injured worker complains of left shoulder pain, bilateral knee pain with popping, left wrist pain with numbness and tingling into the hand, and left elbow pain. Exam of the left wrist noted normal range of motion, tenderness to palpation, positive Phalen's test, and decreased median nerve sensory exam. Exam of the left shoulder noted positive impingement sign, 4/5 motor strength, and tenderness to palpation with range of motion. Exam of the bilateral knees noted tenderness to palpation, positive McMurray's test, crepitus in the left knee, and 4/5 motor strength in bilateral hamstrings and quadriceps. The recommended treatment included physical therapy (2x4), magnetic resonance imaging of the left shoulder, left elbow, left wrist, and bilateral knees, medical physician referral, Functional Capacity Evaluation, x-rays of the cervical spine, left shoulder, left elbow, left wrist, and bilateral knees, electromyogram and nerve conduction studies of the extremities, and medical equipment, including bilateral knee braces, left wrist brace, elbow strap, and cervical pillow.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy for the bilateral knees twice a week for four weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine Page(s): 98-99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98 - 99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Physical medicine treatment.

Decision rationale: MTUS states that active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Per guidelines, 9 visits over 8 weeks are recommend for the medical treatment of derangement of meniscus and Tibialis tendonitis. As time goes, one should see an increase in the active regimen of care or decrease in the passive regimen of care and a fading of treatment of frequency. The injured worker complains of ongoing bilateral knee pain. Documentation provided for review reveals that the injured worker has had previous physical therapy, but there is lack of detailed information regarding the number of visits or objective clinical outcome of the treatment. Given that the injured worker has completed an initial course of physical therapy and there is no report of significant improvement in physical function or exceptional factors, medical necessity for additional physical therapy has not been established. Per guidelines, the request for Physical therapy for the bilateral knees twice a week for four weeks is not medically necessary.

NCV/EMG of the bilateral upper extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 260. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Carpal Tunnel Syndrome Procedure Summary.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): Special Studies and Diagnostic and Treatment Consideration, page 268. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Carpal Tunnel Chapter, Electrodiagnostic studies (EDS), Electromyography (EMG).

Decision rationale: MTUS states that electrodiagnostic studies including nerve conduction studies (NCS), or in more difficult cases, electromyography (EMG), may help differentiate between Carpal Tunnel Syndrome (CTS) and other conditions, such as cervical radiculopathy. NCS and EMG may confirm the diagnosis of CTS but may be normal in early or mild cases of CTS. If the electrodiagnostic studies are negative, tests may be repeated later in the course of treatment if symptoms persist. ODG recommends Electrodiagnostic studies in patients with clinical signs of Carpal Tunnel Syndrome who may be candidates for surgery, but the addition of electromyography (EMG) is not generally necessary. EMG is recommended only in cases where

diagnosis is difficult with nerve conduction studies (NCS), such as when defining whether neuropathy is of demyelinating or axonal type. The injured worker complains of left wrist pain with associated numbness and tingling with clinical signs of neuropathy. Although electrodiagnostic studies of the left wrist is reasonable for further evaluation, documentation fails to show right wrist symptoms or clinical findings to establish the medical necessity for bilateral upper extremity NCV/EMG. The request for NCV/EMG of the bilateral upper extremities is not medically necessary per guidelines.

NCV/EMG of the bilateral lower extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Procedure Summary.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): Special Studies and Diagnostic and Treatment Consideration, page 303.

Decision rationale: MTUS states that Electromyography (EMG) may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks , and to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy. However, EMG's are not necessary if radiculopathy is already clinically obvious. ODG does not recommend Nerve conduction studies (NCS) in the evaluation of low back pain. Documentation fails to indicate that the injured worker has radicular low back symptoms and there no clinical evidence of focal lumbar neurologic dysfunction. The medical necessity for NCV/EMG of the bilateral lower extremity NCV/EMG has not been established. The request for NCV/EMG of the bilateral lower extremities is not medically necessary by MTUS.

MRI of the left shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209 and 214. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Procedure Summary.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): Special Studies and Diagnostic and Treatment Considerations, pg 207.

Decision rationale: MTUS recommends ordering imaging studies when there is evidence of a red flag on physical examination (e.g., indications of intra-abdominal or cardiac problems presenting as shoulder problems), failure to progress in a strengthening program intended to avoid surgery or clarification of the anatomy prior to an invasive procedure (e.g., a full thickness rotator cuff tear not responding to conservative treatment). The injured worker is diagnosed with Left shoulder partial rotator cuff tear with documentation of previous MRI having been performed. Chart documentation fails a significant change in symptoms or unexplained physical findings on examination that would warrant additional imaging. The requester for MRI of the left shoulder is not medically necessary by MTUS.

MRI of the right knee: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee and Leg Procedure Summary.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): Special Studies and Diagnostic and Treatment Considerations, pg 341. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee Chapter.

Decision rationale: Per guidelines, Magnetic resonance imaging (MRI) may be considered if posterior knee dislocation or ligament or cartilage disruption is suspected in the evaluation of soft tissue injuries. MRI should be reserved for situations in which further information is required for a diagnosis, and there is consideration for arthroscopy. The injured worker complains of chronic bilateral knee pain. Documentation fails to reveal acute changes in symptoms or evidence of consideration for arthroscopy that would warrant additional imaging. The request for MRI of the right knee is not medically necessary.

MRI of the left knee: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee and Leg Procedure Summary.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): Special Studies and Diagnostic and Treatment Considerations, pg 341. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee Chapter.

Decision rationale: Per guidelines, Magnetic resonance imaging (MRI) may be considered if posterior knee dislocation or ligament or cartilage disruption is suspected in the evaluation of soft tissue injuries. MRI should be reserved for situations in which further information is required for a diagnosis, and there is consideration for arthroscopy. The injured worker complains of chronic bilateral knee pain. Documentation fails to reveal acute changes in symptoms or evidence of consideration for arthroscopy that would warrant additional imaging. The request for MRI of the left knee is not medically necessary.

MRI of the left wrist: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 268. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Forearm, Wrist & Hand Procedure Summary.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): Special Studies and Diagnostic and Treatment Considerations, pg 268. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hand Chapter.

Decision rationale: MTUS and ODG recommend Magnetic resonance imaging (MRI) in the evaluation of chronic wrist pain only when plain films are normal and other conditions such as soft tissue tumors are suspected. Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. Chart documentation fails to show any red flags or unexplained physical findings on examination and there is no evidence of prior plain X-ray report noted. The medical necessity for MRI has not been established. The request for MRI of the left wrist is not medically necessary per guidelines.

Functional capacity evaluation: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 48. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Fitness for Duty Procedure Summary.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Functional restoration programs (FRPs) Page(s): 49. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Programs.

Decision rationale: Per guidelines, Functional Restorative Programs were designed to use a medically directed, interdisciplinary pain management approach geared specifically to patients with chronic disabling occupational musculoskeletal disorders. They are recommended for patients with conditions that have resulted in delayed recovery. Chart documentation indicates that the injured worker is undergoing active treatment for ongoing left shoulder, bilateral knee, left wrist and left elbow pain. Not having reached maximum medical therapy at the time of the request under review, guidelines have not been met. The request for Functional capacity evaluation is not medically necessary per guidelines.