

Case Number:	CM15-0037223		
Date Assigned:	04/08/2015	Date of Injury:	04/08/2005
Decision Date:	10/19/2015	UR Denial Date:	02/13/2015
Priority:	Standard	Application Received:	02/27/2015

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 60-year-old male who sustained an industrial injury on 4/8/05. He had complaints of neck, upper and lower back pain, hearing and blood pressure problems. Treatments include medication, physical therapy, injections and surgery. Progress note dated 2/3/15 reports continued complaints of pain in his neck, upper and lower back, right shoulder, right elbow and right and left knee. Lower back and bilateral knee pain is constant. Diagnoses include cervical spine disc bulges, thoracic spine strain, lumbar spine surgery, right shoulder strain, right elbow surgery, right knee surgery and left knee strain. Plan of care includes: right shoulder MRI, subacromial injections, right shoulder Synvisc injection right and left knee, 6 sessions chiropractic treatments once every other week, neoprene sleeves for bilateral knees, orthopedist follow up and general surgery consult. Follow up in 3 months.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ortho follow up: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, 2nd edition, Chapter 7-Independent Medical Examinations and Consultations pg 127.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Occupational Medicine Practice Guidelines, Independent Medical Examinations and Consultations Chapter, Page 127.

Decision rationale: In regards to the request for orthopedic consultation, the ACOEM Practice Guidelines recommend expert consultation when the plan or course of care may benefit from additional expertise. Thus, the guidelines are relatively permissive in allowing a requesting provider to refer to specialists. Within the submitted documentation, it is apparent that the worker continues with significant pain in multiple body regions, including the shoulder, bilateral knees, and low back. The patient remains with pain according to the records despite conservative therapies and it is appropriate to have orthopedic follow-up for this worker.

Right shoulder MRI Arthrogram: 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 that 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 Official Disability Guidelines state 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 documentation of chronic shoulder pain. However, the progress note associated with this request from 2/3/15 does not detail any provocative maneuvers to indicate a clear rationale for MRA of the shoulder. There is no discussion of a suspicion for labral tear or any reason for MR arthrogram. Given this, this request is not medically necessary.

Subacromial injection: Upheld

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

MAXIMUS guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Initial Care. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Injection Topic.

Decision rationale: According to the ACOEM Practice guidelines, invasive techniques have limited proven value. If pain with elevation significantly limits activities, a subacromial injection of local anesthetic and a corticosteroid preparation may be indicated after conservative therapy (i.e., strengthening exercises and nonsteroidal anti-inflammatory drugs) for two to three weeks. The evidence supporting such an approach is not overwhelming. The total number of injections should be limited to three per episode, allowing for assessment of benefit between injections. Further guidelines include the ODG, which recommend performing shoulder injections guided by anatomical landmarks alone. Guidelines go on to support the use of corticosteroid injections for adhesive capsulitis, impingement syndrome, or rotator cuff problems, which are not controlled adequately by conservative treatment after at least 3 months, when pain interferes with functional activities. Guidelines state that a 2nd injection is not recommended if the 1st has resulted in complete resolution of symptoms, or if there has been no response. Within the documentation available for review, the recent conservative care of the shoulder is not apparent. The progress note dated 2/3/15 associated with this request lacks a physical of the shoulder and focuses upon the knees and lower back. Given this lack of documentation, the currently requested shoulder injection is not medically necessary.

Right shoulder Synvisc injections right and left knee: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

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, Hyaluronic acid injections.

Decision rationale: Synvisc is a form of viscosupplementation which is FDA approved for knee intra-articular injection. Regarding the request for viscosupplementation, neither the CA MTUS nor the ACOEM Practice Guidelines provide guidelines regarding the use of hyaluronic acid injections. The ODG state that hyaluronic acid injections are recommended as a possible option for severe osteoarthritis for patients who have not responded adequately to recommended conservative treatments. Criteria for Hyaluronic acid injections includes: Patients experience significantly symptomatic osteoarthritis but have not responded adequately to recommended conservative nonpharmacologic (e.g., exercise) and pharmacologic treatments or are intolerant of these therapies (e.g., gastrointestinal problems related to anti-inflammatory medications), after at least 3 months; Documented symptomatic severe osteoarthritis of the knee according to American College of Rheumatology (ACR) criteria, which requires knee pain and at least 5 of the following: (1) Bony enlargement; (2) Bony tenderness; (3) Crepitus (noisy, grating sound) on active motion; (4) Erythrocyte sedimentation rate (ESR) less than 40 mm/hr; (5) Less than 30 minutes of morning stiffness; (6) No palpable warmth of synovium; (7) Over 50 years of age; (8) Rheumatoid factor less than 1:40 titer (agglutination method); (9) Synovial fluid signs (clear fluid of normal viscosity and WBC less than 2000/mm³); Pain interferes with functional

activities (e.g., ambulation, prolonged standing) and not attributed to other forms of joint disease; Failure to adequately respond to aspiration and injection of intra-articular steroids; Generally performed without fluoroscopic or ultrasound guidance; and Are not currently candidates for total knee replacement or who have failed previous knee surgery for their arthritis, unless younger patients wanting to delay total knee replacement. Hyaluronic acid injections are not recommended for any other indications such as chondromalacia patellae, facet joint arthropathy, osteochondritis dissecans, or patellofemoral arthritis, patellofemoral syndrome (patellar knee pain), plantar nerve entrapment syndrome, or for use in joints other than the knee (e.g., ankle, carpo-metacarpal joint, elbow, hip, metatarsophalangeal joint, shoulder, and temporomandibular joint) because the effectiveness of hyaluronic acid injections for these indications has not been established. Within the documentation available for review, the requesting physician has not documented failed conservative treatment including a comprehensive summary of prior physical therapy directed at the knee or any outcome of prior knee steroid injection. Both of these are requisite care to be undertaken prior to viscosupplementation. As such, the current request is not medically necessary.

General surgery consult: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM OMPG Second Edition (2004), Chapter 7, page 127 - Consultation.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Occupational Medicine Practice Guidelines, Independent Medical Examinations and Consultations Chapter, Page 127.

Decision rationale: With regard to the request for specialty consultation, the CA MTUS does not directly address specialty consultation. The ACOEM Practice Guidelines Chapter 7 recommend expert consultation when the plan or course of care may benefit from additional expertise. Thus, the guidelines are relatively permissive in allowing a requesting provider to refer to specialists. However, in this case, the rationale for general surgery consultation is not made clear. The patient has principally musculoskeletal complaints, and there are no industrially related general surgery concerns apparent from a review of the records, especially focusing on recent notes such as the one dated 2/3/15. Given this, this request is not medically necessary.

Lumbar spine injections: Upheld

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

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Physical Methods.

Decision rationale: With regard to the request of lumbar spine injections, page 300 of ACOEM Chapter 12 contains the following excerpt regarding injections: Invasive techniques (e.g., local injections and facet-joint injections of cortisone and lidocaine) are of questionable merit.

Although epidural steroid injections may afford short-term improvement in leg pain and sensory deficits in patients with nerve root compression due to a herniated nucleus pulposus, this treatment offers no significant long-term functional benefit, nor does it reduce the need for surgery. Despite the fact that proof is still lacking, many pain physicians believe that diagnostic and/or therapeutic injections may have benefit in patients presenting in the transitional phase between acute and chronic pain. In this case, there is no specificity as to what type of lumbar spine injection is to be performed. There are numerous types of injections including facets, epidurals, trigger point injections. The progress note associated with this request lacks specificity and this request is not medically appropriate.

Chiro 6 sessions C/S, T/S, L/S, right shoulder 2: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

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. 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. This does not appear to be an initial request as the submitted records include an office note dated 1/31/2013, in which there is a statement that chiropractic resulted in less than 25% improvement and the worker was being evaluated by a chiropractor. Given a lack of previous benefit and no explanation as to what different chiropractic modalities would be employed, this request is not medically necessary.

Neoprene sleeves for bilateral knees: Upheld

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

MAXIMUS guideline: Decision based on MTUS Knee Complaints 2004, Section(s): Activity Alteration. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee Chapter, Knee brace.

Decision rationale: A neoprene sleeve is a type of soft brace for the knee. Regarding the request for a knee brace, ACOEM Practice Guidelines state that a brace can be used for patellar instability, anterior cruciate ligament tear, or medial collateral ligament instability although its benefits "may be more emotional than medical." Usually a brace is necessary only if the patient is going to be stressing the knee under load, such as climbing ladders or carrying boxes. For the average patient, using a brace is usually unnecessary. Furthermore, the ODG state that prefabricated knee bracing (rather than custom) may be appropriate for knee instability, ligament insufficiency, reconstructed ligament, articular defect repair, avascular necrosis, meniscal cartilage repair, painful failed total knee arthroplasty, painful high tibial osteotomy, painful unicompartmental osteoarthritis, and tibial plateau fracture. Custom-fabricated knee braces may be appropriate for patients with abnormal limb contour (valgus or varus deformity), skin changes (i.e., redundant soft skin, thin skin with risk of breakdown), severe osteoarthritis (grade III or IV), maximal off-loading of painful or repaired knee compartment (example: heavy patient; significant pain), and severe instability as noted on physical examination of knee. Within the documentation available for review, there is no indication that the patient has any of the diagnoses for which a knee brace is indicated. There is a lack of exam in the progress note associated with this request to indicate that there is any instability. In the absence of such documentation, the currently requested knee brace is not medically necessary.