

Case Number:	CM14-0163336		
Date Assigned:	10/08/2014	Date of Injury:	01/15/2014
Decision Date:	11/12/2014	UR Denial Date:	09/26/2014
Priority:	Standard	Application Received:	10/03/2014

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. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation and is licensed to practice in Illinois. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 52-year-old female, who reported injury on 01/15/2014. The mechanism of injury was not provided for this review. The injured worker's prior treatment included chiropractic sessions, heat therapy, and medications. On 03/21/2014, the injured worker was evaluated, and it was documented the injured worker complained of right wrist pain when she is working, but was not as severe as it used to. Symptoms radiated to fingers on the left hand. The provider noted her right shoulder had improved overall with treatments. When the injured worker initially started with the treatment, her shoulder felt like it was breaking and tearing. However, she no longer has that feeling. Symptoms on the right side are radiating pain and sharp. The symptoms radiated to the right arm, fingers on the right hand and right forearm. Motor examination revealed there pain and restricted motion was found in the left wrist, right shoulder, and intensity was mild to moderate at a grade 5. Shoulder examination revealed decreased abduction, flexion, internal rotation range of motion, and fixation in the joint capsule was noted. Palpation over the rotator cuff tendons revealed tenderness; palpation examination revealed restriction, tenderness in the anterior shoulder capsule; palpation examination revealed restriction, tenderness in the posterior shoulder capsule; positive orthopedic test impingement. Reflexes were normal and graded equal bilaterally, with the exception of biceps were +2 left and +2 for the right. Triceps were a +2 on the left, and a +2 on the right, and brachioradialis were +2 on the left, and a +2 on the right. Patellar were +2 on the left, and a +2 on the right. Achilles was +2 on the left, and a +2 on the right. Left C8 dermatome was decreased. Flexion range of motion of the shoulder was within normal limits, 170 degrees. Right flexion range of motion was 80/170 degrees with pain. Left extension range of motion was within normal limits, 30 degrees. Right extension range of motion was 30/30 degrees. Left abduction range of motion was within normal limits, 180 degrees. Right abduction range of motion was 70/180 degrees

with pain. Left adduction range of motion was within normal limits, 50 degrees. Right adduction range of motion was 30/50 degrees. Left internal rotation range of motion was within normal limits, 60 degrees. Right internal rotation range of motion was 40/60 degrees. Left external rotation range of motion was within normal limits, 80 degrees. Right external rotation was within normal limits, 80 degrees. It was documented the injured worker had undergone an x-ray of the shoulder on 01/17/2014. Radiographs were taken at the chiropractic office dated 01/17/2014; however, the results were not submitted for this review. The injured worker was evaluated on 03/14/2014 by Atwater Chiropractic that was documented the injured worker had been working 2 days per week, but had not been noticing improvement in her right shoulder. It was also noted that she had not had improvement in her left wrist as well. Adjustments include a manipulated left wrist, right shoulder with mobilization technique and myofascial release. It was documented that the injured worker's home therapies included how to perform the finger walk exercise for shoulder rehabilitation, and to continue the use of cold and heat and the proper application of alternating cold/heat. The diagnoses included rotator cuff sprain/strain, sprain/strain of wrist, specified capsulitis, spasm of muscle, and stiffness. The Request for Authorization was not submitted for this review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Functional Capacity Evaluation right shoulder and left wrist: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Chapter 7: Independent Medical Examinations and Consultations page 132-139

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 77-89. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Fitness for Duty. Functional Capacity Evaluation.

Decision rationale: ACOEM states that an FCE may be necessary to obtain a more precise delineation of the injured worker's capabilities that is available for routine physical examination, under some circumstances. This can best be done by ordering a functional capacity evaluation of the injured worker. The Official Disability Guidelines recommend a functional capacity evaluation may be used prior to admission to a work hardening program with preference for assessment tailored to a specific job or task. The functional capacity evaluation is not recommended as routine use. The documentation is unclear as to how the functional capacity evaluation will aid the provider in the injured worker's treatment plan and goals. There is a lack of findings upon physical exam demonstrating significant functional deficit. There is also a lack of documentation of other treatments the injured worker underwent previously and the measurement of progress as well as the efficacy of the prior treatments. There is a lack of documentation that the injured worker has failed an attempt at work to warrant an FCE at this time to determine restrictions. The provider's rationale for the request was not provided within the medical documents. The guideline recommendations were not met for a FCE. Therefore, the request of Functional Capacity Evaluation right shoulder and left wrist is not medically necessary and appropriate.

Acupuncture for nine sessions to the right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: Acupuncture" is used as an option when pain medication is reduced or not tolerated, it must be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. Frequency and duration of acupuncture or acupuncture with electrical stimulation may be performed as follows: (1) Time to produce functional improvement: 3 to 6 treatments. (2) Frequency: 1 to 3 times per week. (3) Optimum duration: 1 to 2 months. Documents submitted for review failed to include the injured worker's home exercise regimen and outcome measurements. Furthermore, the injured worker had received chiropractic therapy sessions; however, the injured worker still had increased pain. There was no documented functional improvement to receive the chiropractic therapy sessions. As such, the request for acupuncture for 9 sessions for the right shoulder is not medically necessary.

Chiropractic two times a week for six weeks for the right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine, Chiropractic Page(s): 58.

Decision rationale: The California MTUS guidelines state that chiropractic care for chronic pain if caused by musculoskeletal conditions is recommended. 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. The guidelines recommend a trial of 6 visits over 2 weeks, and with evidence of objective functional improvement, a total of up to 18 visits over 6-8 weeks. There was a lack of documentation indicating the injured worker had significant objective functional improvement with the prior therapy. As such, the request for chiropractic 2 times per week for 6 weeks for the right shoulder is not medically necessary.

MRI of the right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 208-209.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-209.

Decision rationale: ACOEM guidelines recommend imaging studies when physiologic evidence identifies Emergence of a red flag (e.g., indications of intra-abdominal or cardiac problems presenting as shoulder problems) Physiologic evidence of tissue insult or neurovascular dysfunction (e.g., cervical root problems presenting as shoulder pain, weakness from a massive rotator cuff tear, or the presence of edema, cyanosis or Raynaud's phenomenon) Failure to progress in a strengthening program intended to avoid surgery. Clarification of the anatomy prior to an invasive procedure (e.g., a full thickness rotator cuff tear not responding to conservative treatment). Imaging studies may be considered for a patient, whose limitations due to consistent symptoms persisted for one month or more, i.e., in cases: When surgery is being considered for a specific anatomic defect (e.g., a full-thickness rotator cuff tear). Magnetic resonance imaging and arthrography have fairly similar diagnostic and therapeutic impact and comparable accuracy although MRI is more sensitive and less specific. Magnetic resonance imaging may be the preferred investigation because it demonstrates soft tissue anatomy better. To further evaluate the possibility of potentially serious pathology, such as a tumor. It was documented the injured worker had X-rays on 01/15/2014; the findings were not submitted for this review. As such, the request for MRI of the right shoulder 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): 271-273.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 268-269.

Decision rationale: The American College of Occupational and Environmental Medicine state that special studies for most patients presenting with true hand and wrist problems, special studies are not needed until after a 4-6 week period of conservative care and observation. Most patients improve quickly provided any red flag conditions are ruled out. If symptoms have not resolved in 4-6 weeks and the patient has joint effusion, serologic studies for Lyme disease and autoimmune diseases may be indicated. Imaging studies to clarify the diagnosis may be warranted if the medical history and physical examination suggests specific disorders. On 03/21/2014, it was documented that the injured worker had pain in her wrist while she was working, but was not as severe as it used to. As such, the request for MRI of the left wrist is not medically necessary.

EMG/NCV for the bilateral upper extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back. Nerve Conduction Studies.

Decision rationale: ACOEM state electromyography is recommended in cases of peripheral nerve impingement. If no improvement or worsening has occurred within 4 to 6 weeks, electrical studies may be indicated. The Guidelines further state that an EMG may be useful to obtain unequivocal evidence of radiculopathy and after 1 month consider conservative therapy, but EMGs are not necessary if radiculopathy is already clinically obvious. California MTUS/ACOEM state that Electromyography (EMG), and nerve conduction velocities (NCV), 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 Official Disability Guidelines do not recommend nerve conduction studies as there is minimal justification for performing nerve conduction studies when an injured worker is presumed to have symptoms on the basis of radiculopathy. The systematic review and metanalysis demonstrate that neurological testing procedures have limited overall diagnostic accuracy in detecting disc herniation with suspected radiculopathy. The management of spine trauma with radicular symptoms, EMG/NCS often has low sensitivity and specificity in confirming root injury and there is limited evidence to support the use of often uncomfortable and costly EMG/NCVS. The included medical documents lack evidence of muscle weakness, decreased sensation, and other symptoms which would indicate nerve impingement. There was no documentation of failed conservative treatment. The provider's rationale was not provided in the medical documents. As such, the request for EMG/NCV (Electromyography / Nerve Conduction Velocity) for the bilateral upper extremities is not medically necessary and appropriate.