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| <b>Case Number:</b>   | CM13-0072341 |                              |            |
| <b>Date Assigned:</b> | 01/08/2014   | <b>Date of Injury:</b>       | 08/06/2012 |
| <b>Decision Date:</b> | 04/22/2014   | <b>UR Denial Date:</b>       | 12/18/2013 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 12/30/2013 |

### 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 and Rehabilitation and is licensed to practice in California. 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 patient is a 44 year old female who was injured on 08/06/2012 while performing her duties as a warehouse clerk. She sustained an injury to her right shoulder, right arm as well as symptoms of depression and problems sleeping. Diagnostic studies reviewed include: MRI of right hand performed on 11/13/2013 which was unremarkable. MRI of the right shoulder performed on 09/28/2013 revealed: 1. Supraspinatus tendinosis 2. Infraspinatus interstitial partial tendon tear Final Determination Letter for IMR Case Number [REDACTED] 3. SLAP type to lesion of the superior glenoid labrum 4. Biceps tendon partial tear and tenosynovitis 5. AC joint osteoarthritis 6. Subacromial/subdeltoid bursitis Electromyography study dated 07/02/2013 revealed abnormal electromyography study of the cervical spine and upper extremities in a pattern consistent with a left C7 radiculopathy. Nerve conduction studies dated 07/02/2013 revealed abnormal nerve conduction velocity/ stead-state evoked potential (NCV/SSEP) of the upper extremities in a pattern consistent with bilateral carpal tunnel syndrome. Comprehensive Drug panel dated 03/19/2013 indicated that Tramadol, Cotinine, Nicotine and O-Desmethyl-cis-Tramadol were detected but no drug was prescribed. PR2 dated 08/01/2013 note indicates the subjective complaints were 5/10 dull to sharp pain to right shoulder and right hand with shooting pain to right hand associated with tingling and numbness in fingers (middle, ring, and little fingers). Objectively, there was tenderness in the right shoulder, painful range of motion (ROM), positive Impingement and tenderness in the right hand. The patient was diagnosed with right shoulder internal derangement and right hand internal derangement. PR2 dated 11/07/2013 note was not completely legible. The subjective complaints were 7/10 sharp pain to right shoulder and right hand with tingling and numbness in fingers. There was no physical exam documented. The patient was diagnosed with right shoulder internal derangement and right hand internal

derangement. Treatment plan was physical therapy 2x6 weeks, acupuncture 1x6 weeks, extracorporeal shock wave therapy (ESWT), and a functional capacity evaluation (FCE).

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **ACUPUNCTURE 1 X WEEK X 6 WEEKS: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**Decision rationale:** As per CA MTUS guidelines, acupuncture is used as an option when pain medication is reduced or not tolerated, it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. Further guidelines indicate acupuncture can be used to reduce pain, reduce inflammation, increase blood flow, increase range of motion, decrease the side effect of medication-induced nausea, promote relaxation in an anxious patient, and reduce muscle spasm. In this case, this patient reports persistent right shoulder and right hand pain associated with numbness and tingling down the fingers. There is a note dated 06/04/2013 that Final Determination Letter for IMR Case Number [REDACTED] indicates this patient has requested acupuncture treatment 1 x6 weeks. It is unclear from the records review whether this patient has been provided the previously recommended acupuncture treatment or not. Also, the available records failed to document detailed objective findings and functional limitations in order to warrant the requested treatment. As such, the request for acupuncture treatment is non-certified.

#### **PHYSICAL THERAPY 2 X WEEK X 6 WEEKS: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physio Therapy Page(s): 98, 9.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

**Decision rationale:** As per CA MTUS guidelines, physical medicine 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. Further guidelines indicate that patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. In this case, this patient reports persistent right shoulder and right hand pain associated with numbness and tingling down the fingers. There is a note dated 06/04/2013 that indicates this patient was requested for physical therapy treatment. It is unclear from the records review whether this patient has been provided the previously recommended physical therapy treatment or not. Also, the available records failed to document detailed objective findings including range of motion, functional limitations, and

difficulty with activities of daily living (ADLs) in order to warrant the requested treatment. As such, the request for physical therapy treatment is non-certified.

**FUNCTIONAL CAPACITY EVALUATION:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Chapt. 7, page 137

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Chapter 7 - Independent Medical Examinations and Consultations, E. Analysis, Functional Capacity Evaluation, pages 510-511

**Decision rationale:** As per ACOEM guidelines, "FCEs may establish physical abilities, and also facilitate the examinee/employer relationship for return to work. In this case, the available records failed to document detailed objective findings, functional limitations, and difficulties with ADLs. There is no documentation that this patient is currently working or has a job to which to return. The return to work plan and goals are not documented. Thus, the medical necessity for the FCE has not been established and the request is non-certified.

**SHOCK WAVE THERAPY (ESWT):** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, (Acute & Chronic), Extracorporeal shock wave therapy (ESWT)

**Decision rationale:** As per CA MTUS guidelines and ODG, ESWT is recommended for calcifying tendinitis but not for other shoulder disorders. In this case, this patient was diagnosed with right shoulder internal derangement and right hand internal derangement. Guidelines only recommend ESWT for calcific tendinitis and there is no reference to support its use for right hand. As such, the medical necessity has not been established and the request is non-certified.