

Case Number:	CM14-0154202		
Date Assigned:	09/23/2014	Date of Injury:	04/04/2013
Decision Date:	10/28/2014	UR Denial Date:	09/08/2014
Priority:	Standard	Application Received:	09/22/2014

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 Anesthesiologist, has a subspecialty in Pain Medicine and is licensed to practice in Florida. 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 40-year-old male who reported injuries due to cumulative trauma on 04/04/2013. On 08/12/2014, his diagnoses included right shoulder impingement syndrome; possible rotator cuff tear; bilateral hand pain; symptoms consistent with carpal tunnel syndrome, improving; bilateral knee pain, possible mild patellofemoral degenerative changes; possible meniscal tear; right knee exostosis of the medial femoral condyle; medial tibial proximal tibial diaphysis; lumbar strain and sprain with L4-5 moderate left foraminal stenosis; L5-S1 annular disc tear with moderate to severe bilateral foraminal stenosis with disc bulge and facet hypertrophy. X-rays of the right shoulder demonstrated normal glenohumeral joint and normal humeral-acromial interval. There were cystic changes noted and the AC joint was minimally hypertrophied. X-rays of the lumbar spine revealed no fractures or subluxations. The disc heights were symmetrical. There was no spondylosis or spondylolisthesis. There was spina bifida occulta of the sacrum S1 level. An MRI of the lumbar spine on 08/15/2014 revealed L4-5 moderate left neural foraminal narrowing and left exiting nerve root compromise. At L5-S1, there was a posterior annular tear and moderate to severe bilateral neural foraminal narrowing in conjunction with facet joint hypertrophy. Bilateral exiting nerve root compromise was seen. Regarding the right shoulder, he had painful limited shoulder range of motion with positive impingement and tenderness, consistent with shoulder bursitis/tendinitis. He stated that he had an unknown number of physical therapy sessions in the past. Treatment plan included a request for physical therapy 2 times a week for 6 weeks followed by a home exercise program. Further request was made for a right shoulder subacromial injection. If he failed conservative treatment, he may have become a candidate for right shoulder surgery. With regard to the bilateral hands, he complained of pain, but no longer had numbness. It was noted that conservative treatment was indicated and that he may be a candidate for injection in the future. Due to his lower back

pain, the request was made for physical therapy 2 times a week for 6 weeks and a pain management consultation for consideration of epidurals or facet injections/rhizotomy. A request for authorization dated 08/12/2014 was included in the injured worker's chart.

IMR ISSUES, DECISIONS AND RATIONALES

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

Subacromial Injection to the Right Shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211-213. Decision based on Non-MTUS Citation Official Disability Guidelines ,Shoulder chapter

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 213.

Decision rationale: The request for subacromial injection to the right shoulder is not medically necessary. The California ACOEM Guidelines note that subacromial injection is not recommended for subacute and chronic impingement syndrome. Prolonged frequent use of cortisone injections into the subacromial space or the shoulder joint is not recommended. The guidelines do not support this injection. Additionally, the medication to have been injected was not specified. Therefore, this request for subacromial injection to the right shoulder is not medically necessary.

Carpal Tunnel Syndrome Injection to the Bilateral Wrists: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Carpel Tunnel Syndrome chapter

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 272.

Decision rationale: The request for carpal tunnel syndrome injection to the bilateral wrists is not medically necessary. The California ACOEM Guidelines recommend that corticosteroid injection is not recommended for all chronic hand, wrist, and forearm disorders. Repeated or frequent in of corticosteroids into carpal tunnel, tendon sheaths, ganglia, etc. is not recommended. The guidelines do not support this injection. Additionally, the medication to have been injected was not specified. Therefore, this request for carpal tunnel syndrome injection to the bilateral wrists is not medically necessary.

Physical Therapy 2 times a week for 6 weeks for the Right Shoulder quantity: 12: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Pain,Suffering and Restoration of function chapter ,page 114.Official Disability Guidelines ,Shoulder chapter

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

Decision rationale: The request for physical therapy 2 times a week for 6 weeks for the right shoulder quantity: 12 is not medically necessary. The California MTUS Guidelines recommend active therapy as indicated for restoring flexibility, strength, endurance, function, range of motion, and to alleviate discomfort. Patients are expected to continue active therapies at home. The physical medicine guideline recommendations for myalgia and myositis unspecified is 9 to 10 visits over 8 weeks. The requested 12 visits of physical therapy exceed the recommendations in the guidelines. Therefore, this request for physical therapy 2 times a week for 6 weeks to the right shoulder quantity: 12 is not medically necessary.

Physical Therapy 2 times a week for 6 weeks for the Lumbar Spine quantity: 12 is not:
Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM ,Pain Suffering and the Restoration of function chapter ,page 114Official Disability Guidelines ,Low Back chapter

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

Decision rationale: The request for physical therapy 2 times a week for 6 weeks for the lumbar spine quantity: 12 is not medically necessary. The California MTUS Guidelines recommend active therapy as indicated for restoring flexibility, strength, endurance, function, range of motion, and to alleviate discomfort. Patients are expected to continue active therapies at home. The physical medicine guideline recommendations for myalgia and myositis unspecified is 9 to 10 visits over 8 weeks. The requested 12 visits of physical therapy exceed the recommendations in the guidelines. Therefore, this request for physical therapy 2 times a week for 6 weeks for the lumbar spine quantity: 12 is not medically necessary.