Case Number:	CM14-0161278		
Date Assigned:	10/06/2014	**Date of Injury:**	05/31/2014
Decision Date:	11/20/2014	**UR Denial Date:**	09/17/2014
Priority:	Standard	**Application Received:**	10/01/2014

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 and Rehabilitation, has a subspecialty in Pain Medicine 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 injured worker is a 57 year old female who reported an injury on 05/31/2014. The mechanism of injury was not provided. She was diagnosed with cervical spine musculoligamentous sprain/strain, lumbar musculoligamentous sprain/strain, bilateral shoulder strain/tendinitis/impingement, bilateral elbow/forearm strain with lateral epicondylitis and cubital tunnel syndrome, bilateral wrist/forearm flexor and extensor tendinitis with carpal tunnel syndrome. The injured worker was treated with therapy, medications, and a brace with activity modification. She had x-rays done of the cervical spine, lumbar spine and bilateral shoulders. The injured worker on 09/05/2014 stated that she had pain in her neck, low back, bilateral shoulders, bilateral elbows bilateral wrist/hand and loss of smell. She stated that she began therapy consisting of stretching, exercise, hot packs, electrical muscle stimulation and massage with a completed ten sessions with only a "slight" benefit. On physical exam, the cervical range motion was flexion measured at 36 degrees, extension measured 42 degrees, right rotation measured 63 degrees, left rotation measured 61 degrees, right side bending measured 34 degrees and left side bending measured 32 degrees. The injured worker's lumbar spine had tenderness to palpation with slight spasm and guarding over the paraspinal musculature, lumbosacral junction and sacrococcyx area bilaterally. Her range of motion was measured as no more than 21 degrees of flexion, extension was no more than 4 degrees, right side bending was measured as 6 degrees and left side bending was measured as 32 degrees. The injured worker's left shoulder examination showed subacromial crepitus and slightly raised acromioclavicular joint bilaterally. The right shoulder range of motion measured flexion at 163, measured extension at 44 degrees, abduction was no more than 158 degrees, adduction was no more than 42 degrees, her internal rotation of the right shoulder measured 74 degrees and the external rotation measured 72 degrees. The injured worker's left shoulder range of motion measured flexion at 167 degrees,

extension was measured at no more than 44 degrees, abduction was no more than 165 degrees, adduction was 40 degrees, her internal rotation of the left shoulder was 71 degrees and the external rotation was 72 degrees. The injured worker had decreased sensation along the median and ulnar nerve distributions bilaterally. The medications were not provided. The treatment plan was for physical therapy, MRI, electrodiagnostic studies and an ultrasound. A request was received for Physical Therapy x8, Home Interferential Unit, and an MRI Scan of Cervical Spine, Electrodiagnostic Studies Bilateral Upper Extremities and Ultrasound Bilateral Shoulders. The rationale was that physical therapy will decrease pain and increase range of motion, the interferential unit to decrease pain and muscle spasm, the MRI scan will assess the cervical spinal discs pathology, the electrodiagnostic to assess for carpal tunnel, cubital tunnel syndrome and cervical radiculopathy and an ultrasound to assess rotator cuff pathology. The Request for Authorization form was submitted on 09/05/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy x8: 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 rationale: The request for Physical Therapy x 8 is not medically necessary. The California MTUS Guidelines recommend 9-10 visits for myalgia and myositis with the fading of treatment frequency, plus active self-directed home physical medicine. The injured worker stated that she had completed 10 visits of therapy. The injured worker reported only slight benefit. It does not appear the injured worker made significant gains in pain relief or function to support the request for additional therapy. In addition, the submitted request fails to specify the site of treatment. Therefore, the request for Physical Therapy x 8 is not medically necessary.

Home Interferential Unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Unit Page(s): 117.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118-119.

Decision rationale: The request for Home Interferential Unit is not medically necessary. The California MTUS Guidelines state interferential current stimulation is not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. If interferential current stimulation is to be used anyway, it is indicated for injured workers whose pain is ineffectively

controlled by medications or unresponsive to conservative treatment. The injured worker stated that she had electrical muscle stimulation and massage and only received a slight benefit. There is no indication the unit would be used in conjunction with recommended treatments, such as return to work. In addition, the request fails to specify the frequency, duration, or site of treatment. As such, the request for the Home Interferential Unit is not medically necessary.

MRI Scan of Cervical Spine: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Spine

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

Decision rationale: The request for MRI Scan of Cervical Spine is not medically necessary. The American College of Occupational and Environmental Medicine Guidelines state that special studies are not needed unless a three or four week period of conservative care has failed to improve symptoms. The criteria for ordering imaging includes: the emergence of a red flag; physiologic evidence of tissue insult or neurovascular dysfunction; failure to progress in a strengthening program intended to avoid surgery; and clarification of the anatomy prior to an invasive procedure. The injured worker stated she began therapy and a completed ten sessions with only a "slight" benefit and activity modifications. There is no indication of the emergence of a red flag, physiologic evidence of neurovascular dysfunction, or the intent to undergo an invasive procedure to support the request for imaging. Therefore, the request for MRI Scan of Cervical Spine is not medically necessary.

Electrodiagnostic Studies Bilateral Upper Extremities: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Official Disability Guidelines Shoulder.

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

Decision rationale: The request for Electrodiagnostic Studies Bilateral Upper Extremities is not medically necessary. The American College of Occupational and Environmental Medicine Guidelines stated special studies are not needed unless a three to four week period of conservative care has not improved symptoms. Electromyography (EMG), and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle focal neurologic dysfunction in injured workers with neck or arm symptoms, or both, lasting more than three or four weeks. The injured worker stated that she was treated therapy, electric muscle stimulation and massage with slight benefit. The injured worker was noted to have decreased sensation in the median and ulnar nerve distributions bilaterally. Motor strength and reflexes were noted to be intact. There is no indication of any significant neurological deficits on physical examination to support the request for electrodiagnostic studies. In addition, the submitted request fails to specify the types

of electrodiagnostic studies being requested. As such, the request for Electrodiagnostic Studies Bilateral Upper Extremities is not medically necessary.

Ultrasound Bilateral Shoulders: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Official Disability Guidelines Shoulder.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 212-214. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder, Ultrasound, diagnostic

Decision rationale: The request for Ultrasound Bilateral Shoulders is not medically necessary. The American College of Occupational and Environmental Medicine Guidelines do not recommend the use of ultrasonography for rotator cuff evaluation. The Official Disability Guidelines state that ultrasound could be used for the detection of full-thickness rotator cuff tears but may be better at picking up partial tears. The injured worker stated that she had pain in her left shoulder that radiated to her wrists and hands. Then, a year later, she had pain in her right shoulder that radiated to her right wrist and hand. There is a lack of significant findings on physical examination to support the request for diagnostic ultrasound. In addition, the guidelines state the use of ultrasonography for rotator cuff evaluation is not recommended. Therefore, the request for Ultrasound Bilateral Shoulders is not medically necessary.