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| <b>Case Number:</b>   | CM14-0176104 |                              |            |
| <b>Date Assigned:</b> | 10/29/2014   | <b>Date of Injury:</b>       | 05/12/2008 |
| <b>Decision Date:</b> | 12/05/2014   | <b>UR Denial Date:</b>       | 09/23/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 10/23/2014 |

### 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 Internal Medicine & Emergency 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:

This patient is a 68 year-old with a date of injury of 05/12/08. A progress report associated with the request for services, dated 09/03/14, identified subjective complaints of pain in the right shoulder and thumb. Objective findings included decreased range of motion with pain in the right shoulder. Finkelstein's test was positive on the right. Diagnoses (paraphrased) included strain/sprain of the right elbow; status post bilateral shoulder and right wrist surgery; and contracture of the MCP joints. Treatment had included medications, physical therapy, and paraffin wax. She underwent right shoulder arthroscopic surgery in 2009 and December of 2013. A Utilization Review determination was rendered on 09/23/14 recommending non-certification of "Physical Therapy Once Weekly for 6 Weeks, Right Shoulder and Right Thumb; Acupuncture Once Weekly for 6 Weeks, Body Part Unspecified; and Ultrasound Guided Cortisone Injection Right Thumb And Paraffin Wax".

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical Therapy Once Weekly For 6 Weeks, Right Shoulder And Right Thumb:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Physical Therapy

**Decision rationale:** The Chronic Pain section of the Medical Treatment Utilization Schedule (MTUS) recommends physical therapy with fading of treatment frequency associated with "... active therapies at home as an extension of the treatment process in order to maintain improvement levels." Specifically, for myalgia and myositis, 9-10 visits over 8 weeks. For neuralgia, neuritis, and radiculitis, 8-10 visits over 4 weeks. The Official Disability Guidelines (ODG) states that for shoulder strain and impingement or rotator cuff syndrome, 10 visits over 8 weeks are recommended. The patient has received an unspecified number of previous physical therapy sessions. An additional 6 sessions are requested, which may exceed the recommendation of 10 visits. Functional improvement must be clearly defined for additional physical therapy. In this case, the record does not document previous functional improvement and therefore the medical necessity for 6 additional physical therapy sessions.

**Acupuncture Once Weekly For 6 Weeks, Body Part Unspecified:** Upheld

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

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

**Decision rationale:** The Medical Treatment Utilization Schedule (MTUS) states that acupuncture is used as an option when pain medication is reduced or not tolerated, or as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. It further states that 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. The frequency and duration of acupuncture is listed as:-Time to produce functional improvement: 3 to 6 treatments.-Frequency: 1 to 3 times per week.-Optimum duration: 1 to 2 months. The request does not specify the location / body part for acupuncture. Therefore, there is no documented medical necessity for acupuncture as requested.

**Ultrasound Guided Cortisone Injection Right Thumb And Paraffin Wax:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 271-272. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hand, Percutaneous release (of the trigger finger and/or trigger thumb)

**Decision rationale:** The Medical Treatment Utilization Schedule (MTUS) states that steroid injections into the flexor tendon sheath are almost always sufficient to cure symptoms and restore function. They note that a procedure under local anesthesia may be necessary to

permanently correct persistent triggering. The Official Disability Guidelines (ODG) also recommends injection "where symptoms persist." They also note that percutaneous release along with steroid injection provides satisfactory results in 91% of cases as opposed to steroid injection alone. However, the need to perform the procedure with ultrasound guidance is not a recommendation and the record does not document any special circumstances that would necessitate the use of ultrasound. Therefore, the record does not document the medical necessity for an ultrasound-guided steroid injection.