

<b>Case Number:</b>	CM14-0025407		
<b>Date Assigned:</b>	06/13/2014	<b>Date of Injury:</b>	12/30/2013
<b>Decision Date:</b>	07/22/2014	<b>UR Denial Date:</b>	02/06/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/28/2014

### 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 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 37 year old male who was injured on 12/30/2013 when he fell from 12 feet high and landed on his back. Past medication history include Voltaren XR 100 mg #60, Protonix 20 mg #30, and Norco 2.5 mg #60 tablets. Diagnostic studies reviewed include x-rays of the cervical spine, thoracic spine, and lumbar spine demonstrated mild degenerative changes, x-rays of the pelvis findings are within normal limits; and x-rays of the right knee are within normal limits. Ortho report dated 01/29/2014 indicates the patient complains of pain with tenderness and limited range of motion. He has weakness in the cervical spine with radiation of pain into both shoulder girdles. He also has upper back pain with numbness and tingling radiating into the right upper extremity. There is pain in the thoracic and lumbar spine with limited range of motion and weakness, right knee and right shoulder pain with weakness and tenderness and right thigh pain with tenderness and a soft tissue mass of the right thigh. Objective findings on exam revealed walks with a non antalgic gait and is able to heel and toe walk without difficulty. There is tenderness to palpation in the upper, mid, and lower paravertebral and trapezius muscle. The range of motion flexion is to within 40 degrees with 30 degrees right lateral bending, 40 degrees left lateral bending, 50 degrees right lateral rotation, 50 degrees left lateral rotation, and 40 degrees extension. There is an increased pain with cervical motion. The right shoulder revealed there is tenderness to palpation over the anterior rotator cuff. There is mild AC joint and bicipital tenderness without irritability. There is a positive impingement sign. There is grade IV/V rotator cuff/deltoid biceps strength. Range of motion: Flexion 165 degrees, Abduction 150 degrees, Extension 40 degrees, External rotation 40 degrees, internal rotation 30 degrees and Adduction 40 degrees. The lumbar spine revealed tenderness. Range of motion exhibits flexion to within 25 degrees, 15 degrees right lateral bending, 15 degrees left lateral bending, 20 degrees right lateral rotation, 10 degrees left lateral rotation and extension 10 degrees. The right knee revealed

tenderness to palpation over the lateral joint line. There is lateral pain with McMurray Maneuver. The range of motion is from 0-125 degrees. It is noted that the mass on the right thigh may represent a hematoma. Diagnoses are scalp laceration, closed head injury, cervical, thoracic, and lumbar spine strain, right cervical radiculopathy, and contusion and straining injury of the right hip and pelvis, internal derangement of the right knee, right rotator cuff tendinitis, and impingement syndrome and straining injury of the chest. It has been recommended to continue medical treatment. There is a request for physiotherapy with multiple modalities to the affected body regions including hot and cold therapy, massage, ultrasound, electrical stimulation, manual deep tissue massage and infrared heat 2 times a week for 6 weeks.

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

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

**PHYSICAL THERAPY TWO (2) TIMES A WEEK FOR SIX (6) WEEKS FOR THE LUMBAR SPINE, CERVICAL SPINE, RIGHT KNEE AND RIGHT SHOULDER (QTY: 12):** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG 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), Low Back, Physical Therapy; Neck and Upper Back, Physical Therapy; Knee & Leg, Physical Therapy; & Shoulder, Physical Therapy.

**Decision rationale:** The patient does not appear to have had physical therapy previously. According to the ODG, physical therapy is recommended for 10-12 visits over 8 weeks for sprains of the above-mentioned body parts. Medical necessity is established for 12 visits of physical therapy.

**RIGHT KNEE MRI AND RIGHT THIGH MRI:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 341-343. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee & Leg & Hips and Pelvis, MRI.

**Decision rationale:** The ACOEM Guidelines and ODG recommend knee MRI after significant acute trauma. However, the patient does not have complaints or findings on exam suggestive of ligamentous or cartilaginous disruption or other mechanical derangement. There are no red flag findings. There has not been a trial of conservative therapy. A right knee and thigh MRI performed on 2/18/14 showed medical meniscus intrasubstance degeneration without signs of acute trauma. As such, the request is not medically necessary and appropriate.

**RIGHT SHOULDER MRI: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-209. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, MRI.

**Decision rationale:** The ACOEM Guidelines and ODG recommend shoulder MRIs after acute trauma or suspected rotator cuff tear. However, the patient does not have complaints or findings on exam suggestive of rotator cuff tear or other mechanical derangement. There are no red flag findings. There has not been a trial of conservative treatment. A right shoulder MRI performed on 2/18/14 showed AC joint arthritis and rotator cuff tendinitis without signs of acute trauma. As such, the request is not medically necessary and appropriate.

**PROTONIX 20MG #30: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms, and Cardiovascular Risk Page(s): 68-69. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, NSAIDs.

**Decision rationale:** The patient is prescribed Voltaren. However, there is no documentation of gastrointestinal side effects or intermediate to high risk of gastrointestinal side effects due to NSAID use. As such, the request is not medically necessary and appropriate.