

<b>Case Number:</b>	CM14-0194873		
<b>Date Assigned:</b>	12/03/2014	<b>Date of Injury:</b>	04/11/2014
<b>Decision Date:</b>	01/16/2015	<b>UR Denial Date:</b>	11/11/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/20/2014

### 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 48 year old female with date of injury 04/11/14. The treating physician report dated 10/31/14 (163) indicates that the patient presents with pain affecting her neck, shoulder and right hand. The physical examination findings reveal for the Cervical Spine: visual inspection of the cervical spine and adjacent paraspinal structures is absent evidence of gross anomaly or deformity; there is cervical paraspinal tenderness and hypertonicity; upper trapezium guarding and tenderness on the left; cervical motions are restricted and painful; deep tendon reflexes are judged +0/4 bilaterally at the biceps and triceps tendons; Upper extremity pulses are present and sensations are intact. There is left should pain reported during ROM testing. Neer and Hawkin's testing are positive on the left. There is no obvious atrophy in either upper extremity. MRI findings dated 10/20/14 reveal signs of tendonitis of multiple flexor and extensor tendons at the radial writ. Prior treatment includes Physical Therapy two times per week, and chiropractic manipulative therapy one time per week. The current diagnoses are:1.Cervical spine sprain-strain, rule out discopathy2.Left should sprain-strain, rule out internal derangement3.Tendonitis, right hand and fingers4.Hypertension, patient instructed to follow up with personal physician. The utilization review report dated 11/11/14 denied the request for Physical Therapy, ESWT, and MRI of the Left Wrist based on lack of medical necessity.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy x6 for the cervical spine & left shoulder: 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 Page(s): 98, 99.

**Decision rationale:** The patient presents with neck, shoulder, and wrist pain. The current request is for Physical Therapy x6 for the cervical spine and left shoulder. The treating physician indicates that the current request is to assist the patient in improving their pain and functions of daily living. The treating physician report dated 10/31/14 indicates that the patient has already completed six sessions of PT and they are requesting an additional 6. The MTUS Guidelines supports physical therapy and states for, "Myalgia, myositis and neuritis type conditions, unspecified (ICD9 729.1): 8-10 visits over 8 weeks." There is no documentation of any new injuries or rationale as to why additional physical therapy is required at this juncture following a previous round of PT less than 6 months prior to this request. In this case the current request would exceed the MTUS recommendation of 8-10 visits. Therefore, this request is not medically necessary.

**3-5 ESWT (extracorporeal shock wave therapy) treatments for the left shoulder:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Online Shoulder Chapter, ESWT Section

**Decision rationale:** The patient presents with neck, shoulder, and wrist pain. The current request is for 3-5 ESWT. The treating physician indicates that the current request is for extracorporeal shock wave treatment (ESWT) of the right rotator cuff tendinitis/tendinosis. The ODG guidelines state, Recommended for calcifying tendinitis but not for other shoulder disorders." The guidelines also go on to provide specific criteria, which includes, "1. Patients whose pain from calcifying tendinitis of the shoulder has remained despite six months of stand treatment. 2. At least three conservative treatments had been performed prior to use of ESWT. 3. Maximum of 3 therapy sessions over 3 weeks." In this case the physician has requested ESWT for the treatment of rotator cuff tendonitis which is not supported by ODG. The current request also exceeds the recommended 3 therapy sessions. Therefore, this request is not medically necessary.

**MRI (magnetic resonance imaging) of the left wrist:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Online Forearm, Wrist, and Hand Chapter, MRI section

**Decision rationale:** The patient presents with neck, shoulder, and wrist pain. The current request is for MRI of the left wrist. The treating physician does not indicate what the current request is for. There is no documentation indicating there is any problem with the left wrist in the treating physician report dated 10/24/14 or 10/31/14. The ODG guidelines recommend MRI's as long as the following indications are met, "Acute hand or wrist trauma, suspect acute distal radius or scaphoid fracture, radiographs normal, next procedure if immediate confirmation or exclusion of fracture is required; acute hand or wrist trauma, suspect gamekeeper injury; chronic wrist pain, plain films normal, suspect soft tissue tumor; Chronic wrist pain, plain film normal or equivocal, suspect Kienbock's disease; Repeat MRI is not routinely recommended" In this case there is no indication that the patient was suffering from pain of the left wrist or had any complaints about the left wrist. Ultimately the documentation provided does not fulfill the requirements as outlined in the ODG guidelines. Therefore, this request is not medically necessary.