

<b>Case Number:</b>	CM14-0205242		
<b>Date Assigned:</b>	12/17/2014	<b>Date of Injury:</b>	09/12/2013
<b>Decision Date:</b>	02/06/2015	<b>UR Denial Date:</b>	11/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/08/2014

### 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 Orthopedic Surgery 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:

According to the records made available for review, this is a 56-year-old male with a 9/12/13 date of injury, and rotator cuff repair on 2/27/14. At the time (11/11/14) of request for authorization for 12 physical therapy sessions of the lumbar spine, 12 physical therapy bilateral hands, lumbar cold pack with strap, 2 Lidocaine injections, Spica splints, and MRI arthrogram of the right shoulder, there is documentation of subjective (right shoulder, bilateral hands, and low back pain) and objective (decreased cervical, lumbar, and shoulder range of motion; positive right Neer's sign; positive right Hawkin's sign; tenderness over the thumb basilar joint, subacromial joint, biceps tendon, and anterior glenohumeral joint; and diminished bilateral lower extremity reflexes) findings, current diagnoses (bilateral basilar joint degenerative changes and lumbar spine degenerative disc disease), and treatment to date (medications). Regarding 12 physical therapy sessions of the lumbar spine and 12 physical therapy bilateral hands, it cannot be determined if this is a request for initial or additional physical therapy. Regarding lumbar cold pack with strap, there is no documentation of acute pain. Regarding 2 Lidocaine injections, there is no documentation of a condition/diagnosis (with supportive subjective/objective findings) for which thumb joint injection is indicated (arthritis of the CMC joint). Regarding Spica splints, there is no documentation of a condition/diagnosis (with supportive subjective/objective findings) for which a wrist splint is indicated. Regarding MRI arthrogram of the right shoulder, there is no documentation of suspected subtle tears that are full thickness or suspected labral tear.

### IMR ISSUES, DECISIONS AND RATIONALES

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

## **12 Physical Therapy Sessions of The Lumbar Spine: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Physical therapy (PT).

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines support a brief course of physical medicine for patients with chronic pain not to exceed 10 visits over 4-8 weeks with allowance for fading of treatment frequency, with transition to an active self-directed program of independent home physical medicine/therapeutic exercise. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. ODG recommends a limited course of physical therapy for patients with a diagnosis of Intervertebral disc disorders not to exceed 10 visits over 8 weeks. ODG also notes patients should be formally assessed after a "six-visit clinical trial" to see if the patient is moving in a positive direction, no direction, or a negative direction (prior to continuing with the physical therapy) and when treatment requests exceeds guideline recommendations, the physician must provide a statement of exceptional factors to justify going outside of guideline parameters. Within the medical information available for review, there is documentation of diagnoses of bilateral basilar joint degenerative changes and lumbar spine degenerative disc disease. In addition, given documentation of subjective (low back pain) and objective (decreased lumbar range of motion) findings, there is documentation of functional deficits and functional goals. However, given documentation of a 9/12/13 date of injury where there would have been an opportunity to have had previous physical therapy, it is not clear if this is a request for initial or additional (where physical therapy provided to date may have already exceeded guidelines regarding a time-limited plan and there is the necessity of documenting functional improvement) physical therapy treatment. Therefore, based on guidelines and a review of the evidence, the request for 12 physical therapy sessions of the lumbar spine is not medically necessary.

## **12 Physical Therapy Bilateral Hands: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist, & Hand, Physical therapy (PT).

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines support a brief course of physical medicine for patients with chronic pain not to exceed 10 visits over 4-8 weeks with allowance for fading of treatment frequency, with transition to an active self-directed program of independent home physical medicine/therapeutic exercise. MTUS-Definitions identifies that any

treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. ODG recommends a limited course of physical therapy for patients with a diagnosis of Sprains and strains of wrist and hand not to exceed 9 visits over 8 weeks. ODG also notes patients should be formally assessed after a "six-visit clinical trial" to see if the patient is moving in a positive direction, no direction, or a negative direction (prior to continuing with the physical therapy) and when treatment requests exceeds guideline recommendations, the physician must provide a statement of exceptional factors to justify going outside of guideline parameters. Within the medical information available for review, there is documentation of diagnoses of bilateral basilar joint degenerative changes and lumbar spine degenerative disc disease. In addition, given documentation of subjective (bilateral hand pain) and objective (tenderness over the thumb basilar joint) findings, there is documentation of functional deficits and functional goals. However, given documentation of a 9/12/13 date of injury where there would have been an opportunity to have had previous physical therapy, it is not clear if this is a request for initial or additional (where physical therapy provided to date may have already exceeded guidelines regarding a time-limited plan and there is the necessity of documenting functional improvement) physical therapy treatment. Therefore, based on guidelines and a review of the evidence, the request for 12 physical therapy bilateral hands is not medically necessary.

### **Lumbar Cold Pack with Strap: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 356.

**Decision rationale:** MTUS reference to ACOEM guidelines identifies documentation of acute pain, as criteria necessary to support the medical necessity of cold pack. Within the medical information available for review, there is documentation of diagnoses of bilateral basilar joint degenerative changes and lumbar spine degenerative disc disease. However, despite documentation of subjective findings (subjective (right shoulder, bilateral hands, and low back pain), and given documentation of a 9/12/13 date of injury, there is no (clear) documentation of acute pain. Therefore, based on guidelines and a review of the evidence, the request for lumbar cold pack with strap is not medically necessary.

### **2 Lidocaine Injections: Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence:

<https://www.rushortho.com/pdf/Injection%20Therapy%20in%20the%20Management%20of%20the%20Hand%20and%20Wrist.pdf>.

**Decision rationale:** MTUS and ODG do not address this issue. Medical Treatment Guidelines identifies documentation of a condition/diagnosis (with supportive subjective/objective findings) for which thumb joint injection is indicated (such as arthritis of the CMC joint), as criteria necessary to support the medical necessity of thumb joint injection. Within the medical information available for review, there is documentation of diagnoses of bilateral basilar joint degenerative changes and lumbar spine degenerative disc disease. However, despite documentation of subjective (bilateral hand pain) and objective (tenderness over the thumb basilar joint) findings, there is no documentation of a condition/diagnosis (with supportive subjective/objective findings) for which thumb joint injection is indicated (arthritis of the CMC joint). Therefore, based on guidelines and a review of the evidence, the request for 2 Lidocaine injections is not medically necessary.

**Spica Splints:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 271-273, TABLE 11-7.

**Decision rationale:** MTUS reference to ACOEM guidelines identifies documentation of a condition/diagnosis (with supportive subjective/objective findings) for which a wrist splint is indicated (such as: acute, subacute, or chronic CTS; moderate or severe acute or subacute wrist sprains; acute, subacute, or chronic ulnar nerve compression at the wrist; acute, subacute, or chronic radial nerve neuropathy; scaphoid tubercle fractures; acute flares or chronic hand osteoarthritis; Colles' fracture; or select cases (i.e., patients who decline injection) of acute, subacute, or chronic flexor tendon entrapment), as criteria necessary to support the medical necessity of wrist splinting. Within the medical information available for review, there is documentation of diagnoses of bilateral basilar joint degenerative changes and lumbar spine degenerative disc disease. However, despite documentation of subjective (bilateral hand pain) and objective (tenderness over the thumb basilar joint) findings, there is no documentation of a condition/diagnosis (with supportive subjective/objective findings) for which a wrist splint is indicated. Therefore, based on guidelines and a review of the evidence, the request for Spica splints is not medically necessary.

**MRI Arthrogram of The Right Shoulder:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 208. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Arthrography.

**Decision rationale:** MTUS reference to ACOEM guidelines identifies that imaging may be considered for a patient whose limitations due to consistent symptoms have persisted for one month or more; and that magnetic resonance imaging and arthrography have fairly similar diagnostic and therapeutic impact and comparable accuracy. ODG identifies that subtle tears that are full thickness are best imaged by arthrography and that MR arthrography is usually necessary to diagnose labral tears. Within the medical information available for review, there is documentation of diagnoses of bilateral basilar joint degenerative changes and lumbar spine degenerative disc disease. However, there is no documentation of suspected subtle tears that are full thickness or suspected labral tear. Therefore, based on guidelines and a review of the evidence, the request for MRI arthrogram of the right shoulder is not medically necessary.