MAXIMUS Federal Services

Case Number:	CM15-0003321		
Date Assigned:	01/14/2015	Date of Injury:	05/29/2012
Decision Date:	03/30/2015	UR Denial Date:	12/10/2014
Priority:	Standard	Application Received:	01/07/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: New York
Certification(s)/Specialty: Internal Medicine

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 male patient, who sustained an industrial injury on 05/29/2012. A secondary treating follow up visit dated 11/05/2014 reported objective findings of hypertension, gastritis, headache and hemorrhoids. A primary treating visit dated 11/18/2014 reported the patient continues with shoulder pain. The pain is reported as constant, severe cervical spine pain that radiates into the bilateral shoulders and is also noted as achy. In addition, the patient has complaint of daily headaches over bilateral parietal lobes accompanied with blurred vision. He completed a course of postoperative physical therapy and was taught home exercises. The injured worker reported while performing home exercise specifically while attempting to increase range of motion, he felt increased pain, popping and clicking in his shoulder. The primary treating is requesting a surgical follow up and an MRI on the right shoulder. He is also prescribed another course of physical therapy for re-education. Furthermore, the physician stated that secondary to the findings in the cervical spine and lumbar MRI and examination then requested chiropractic sessions to increase range of motion and decrease pain. The patient is also described as a good candidate for extracorporeal shockwave therapy as he's found with mild tendonitis specifically to the shoulder, cervical and lumbar spine. Pending at that time, noted a scheduled appointment for electroencephalogram. A pain management follow up visit dated 10/14/2014 reported a treatment history as follows; 03/04/2013, and 07/25/2013 underwent cervical facet joint injections; he underwent left inguinal hernia repair on 02/2014; and underwent arthroscopic right shoulder surgery on 05/14/2014. He is prescribed the following medications; Norco 10/325 MG, Anaprox DS, Fexmid, Prilosec, Topamax and Colace. He was

diagnosed with cervical myoligamentous injury with right upper extremity radiculopathy and associated cervicogenic headaches; lumbar myoligamentous injury with left sided radulcular symptoms; post concussion head syndrome, medication induced gastritis with chronic constipation leading to hemorrhoids. On 12/10/2014 Utilization Review non-certified the following; 8 physical therapy session treating neck and right shoulder; 6 acupuncture sessions treating the neck and back; 6 chiropractic sessions treating the neck and back; 6 extracorporeal shockwave treatments treating the neck and back; MRI of the right shoulder; MRI of the cervical spine; an orthopedic followup for second opinion regarding right shoulder and a hernia evaluation. On 01/07/2015 IMR application was received.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy, twice weekly for four weeks: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98 ? 99. Decision based on Non-MTUS Citation Physical Therapy Chapter

Decision rationale: MTUS and ODG guidelines recommend 10 physical therapy visits over 8 weeks for medical management of neck sprains and strains and Intervertebral disc disorders without myelopathy, and 24 visits over 14 weeks for Post-surgical treatment, for arthroscopic shoulder surgery. The MTUS for post-surgical physical medicine states that post-surgical physical therapy is for functional improvement. As time goes, one should see an increase in the active regimen of care or decrease in the passive regimen of care, with a fading of treatment of frequency (from up to 3 or more visits per week to 1 or less). When the treatment duration and/or number of visits exceeds the guidelines, exceptional factors should be noted. At the time additional outpatient physical therapy was prescribed, the injured worker had completed at least 12 visits, followed by a home exercise program with no evidence of functional improvement. The medical necessity for additional outpatient physical therapy has not been established. Per guidelines, the request for 8 physical therapy sessions is not medically necessary.

Acupuncture, once weekly for six weeks: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines. Decision based on Non-MTUS Citation Pain Chapter

Decision rationale: MTUS states that Acupuncture is not recommended for neck pain and is recommended in the management of back pain only when used as an adjunct to active physical rehabilitation and/or surgical intervention to hasten functional recovery. Documentation indicates that the injured worker has chronic low back pain for which surgical intervention has been

declined. In addition, there was no evidence of other active physical rehabilitation at the time of the request for acupuncture. The request for Acupuncture, once weekly for six weeks is not medically necessary by MTUS and ODG guidelines.

Extracorporeal shockwave therapy, once weekly for six weeks: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Not addressed. Decision based on Non-MTUS Citation International Society for Medical Shockwave Therapy

Decision rationale: Per the International Society for Medical Shockwave Therapy, Extracorporeal Shockwave Treatment (ESWT) is approved for the treatment of chronic tendinopathies, impaired bone healing function (example,stress fractures, avascular necrosis) and Lithotripsy. The injured worker is diagnosed with Lumbar spine herniated nucleus pulposus and Cervical spine myololigamentous injury, which do not fit the criteria for use of ESWT. The request for Extracorporeal shockwave therapy, once weekly for six weeks for treating the neck and back is not medically necessary.

Chiro, once weekly for six weeks: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58. Decision based on Non-MTUS Citation Low Back Chapter, Neck Chapter

Decision rationale: Per guidelines, Chiropractic treatment is recommended for chronic pain if caused by musculoskeletal conditions. MTUS and ODG state that it is not medically necessary to use chiropractic care for elective or maintenance care. Previous MRI revealed Cervical Spine degenerative disc disease and spinal stenosis and multi-level Lumbar spine degenerative disc disease. The injured worker complaints of chronic ongoing neck and low back pain, with no documentation of acute exacerbation of symptoms. With MTUS and ODG guidelines not being met, the request for Chiro, once weekly for six weeks, is not medically necessary.

MRI of the right shoulder, with contrast: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): Special Studies and Diagnostic and Treatment Considerations, pg 207.

Decision rationale: MTUS recommends ordering imaging studies when there is evidence of a red flag on physical examination (e.g., indications of intra-abdominal or cardiac problems presenting as shoulder problems), failure to progress in a strengthening program intended to avoid surgery or clarification of the anatomy prior to an invasive procedure (e.g., a full thickness rotator cuff tear not responding to conservative treatment). The injured worker has undergone arthroscopic shoulder surgery and post- operative Physical Therapy with no significant improvement in pain or function. Chart documentation fails to show any red flags or unexplained physical findings on examination that would warrant additional imaging. The request for MRI of the right shoulder is not medically necessary by MTUS.

MRI of the cervical spine, plain: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): Special Studies and Diagnostic and Treatment Considerations, pg 177.

Decision rationale: MTUS recommends spine x rays in patients with neck pain only when there is evidence of red flags for serious spinal pathology. Imaging in patients who do not respond to treatment may be warranted if there are objective findings that identify specific nerve compromise on the neurologic examination and if surgery is being considered as an option. There is no physician report of definitive neurologic findings on physical exam that would meet the indication for additional imaging. The request for MRI of the cervical spine, plain, is not medically necessary.

Orthopedic follow-up for the right shoulder: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines nonspecific. Decision based on Non-MTUS Citation Shoulder Chapter, Office visits

Decision rationale: Per Guidelines, the value of patient/doctor interventions has not been questioned. The need for a clinical office visit with a health care provider is individualized upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. Guidelines state that a set number of office visits per condition cannot be reasonably established as patient conditions vary. The injured worker complaints of persistent right shoulder pain despite multiple treatment modalities, including surgery, medications and physical therapy. Per guidelines, the request for Orthopedic follow-up for the right shoulder is medically necessary.

Second opinion hernia evaluation: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Not addressed. Decision based on Non-MTUS Citation American College of Physicians (ACP), Inguinal Hernia

Decision rationale: The American College of Physicians recommends consulting a general surgeon for the evaluation of early and late complications of hernia surgery, which may include hematoma, hernia recurrence, persistent numbness and chronic groin pain if it persists for more than three months and interferes with normal activities. The injured worker complaints of persistent groin pain following left inguinal hernia repair over 8 months prior to the request for the surgery consult under review. Per guidelines, the request for second opinion hernia evaluation is medically necessary.