MAXIMUS Federal Services

Case Number:	CM15-0025260		
Date Assigned:	02/17/2015	Date of Injury:	01/14/2013
Decision Date:	04/07/2015	UR Denial Date:	01/28/2015
Priority:	Standard	Application Received:	02/10/2015

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: California
Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 46 year old female who sustained an industrial related injury on 1/14/13. The injured worker had complaints of neck, back, bilateral elbow, bilateral wrist, bilateral hand, bilateral hip, and left knee pain. Diagnoses included cervical spine disc bulges, thoracic spine strain, lumbar spine strain, bilateral elbow strain, bilateral wrist/hand strain, bilateral hip strain, and left knee internal derangement. The treating physician requested authorization for MRI of the lumbar spine, shock wave therapy for the right wrist 1 time per week for 3 weeks, and x-rays of bilateral hips. On 1/28/15 the requests were non-certified. Regarding the MRI, the utilization review (UR) physician cited the Official Disability Guidelines (ODG) and noted there was no documentation of significant change in symptoms or physical findings of the lumbar spine. There was also a general lack of information regarding the physical examination. Therefore, the request was non-certified. Regarding shock wave therapy, the UR physician noted there was no documentation of a wrist examination noting a specific diagnosis and there are no studies to support the treatment of shock wave therapy for wrist pain. Regarding hip x-rays, the UR physician cited ODG and noted there was no documentation of an examination of the hips suggesting an injury or pathology following a recent fall. Therefore, the requests were non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of the lumbar spine: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines- Low Back-Lumbar & Thoracic.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Low back chapter, MRIs (magnetic resonance imaging).

Decision rationale: The patient presents with complaints of low back pain that radiates to the left foot. The request is for MRI OF THE LUMBAR SPINE. The RFA provided is dated 12/29/14. Patient's diagnosis included lumbar spine strain and bilateral hip strain. Physical examination findings were not provided. Per the UR letter dated 01/28/15, the RFA dated 11/26/14 included EMG upper/lower extremities (results not provided), acupuncture 2X6 to the neck/lower back, and H Wave treatment. The patient was to remain off work for 6 weeks.ODG guidelines, Low back chapter, MRIs (magnetic resonance imaging) (L-spine) state that "for uncomplicated back pain MRIs are recommended for radiculopathy following at least one month of conservative treatment." ODG guidelines further state the following regarding MRI's, "Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (e.g., tumor, infection, fracture, neurocompression, recurrent disc herniation)."The treater does not provide a rationale for the request of lumbar MRI. Review of medical records does not show a prior MRI of L-spine. Per the UR letter dated 01/28/15, the RFA dated 11/26/14 included EMG upper/lower extremities; however, results were not discussed. Physical examination findings were not provided either. In this case, the patient has failed conservative care and has radiating pain down to the ankle. MRI of L-spine to rule out disc herniation/stenosis and other potential conditions is reasonable. The request IS medically necessary.

Shock wave therapy for the right wrist 1 time a week for 3 weeks: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203. Decision based on Non-MTUS Citation Official disability guidelines Shoulder chapter, ESWT.

Decision rationale: The patient presents with complaints of bilateral wrist and bilateral hand pain. The request is for SHOCK WAVE THERAPY FOR THE RIGHT WRIST 1 TIME A WEEK FOR 3 WEEKS. The RFA provided is dated 12/29/14. Patient's diagnosis included cervical spine disc bulges, thoracic spine strain, bilateral elbow strain, and bilateral wrist/hand strain. The patient was to remain off work for 6 weeks. MTUS/ACOEM, Chapter 9, Shoulder Complaints, page 203, under Initial Care, states: Some medium quality evidence supports manual physical therapy, ultrasound, and high energy extracorporeal shock wave therapy for

calcifying tendinitis of the shoulder. ODG guidelines, Shoulder chapter online, for ESWT states: Recommended for calcifying tendinitis but not for other shoulder disorders. MTUS and ODG guidelines have support for shockwave therapy for calcifying tendinitis of the shoulder, but not for other shoulder disorders. The available reporting does not show evidence of calcifying tendinitis. The request for Ortho-shockwave therapy, unknown frequency, is not in accordance with MTUS guidelines and IS NOT medically necessary. The request for shock therapy is being requested for the right wrist. Extracorporeal shock-wave therapy is indicated for the shoulder with diagnosis of calcifying tendonitis and not for other musculoskeletal indications. Furthermore, there is no documentation of a wrist examination or any specific pertinent diagnosis. The request is not in accordance with guideline indications. Therefore, the request IS NOT medically necessary.

X ray of the right hip: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines- Hip & Pelvis.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Hip & Pelvis chapter, X-ray.

Decision rationale: The patient presents with complaints of bilateral hip and low back pain that radiates to the left foot. The request is for X RAY OF THE RIGHT HIP. The RFA provided is dated 12/29/14. Patient's diagnosis included lumbar spine strain and bilateral hip strain. Physical examination findings were not provided. Per the UR letter dated 01/28/15, the RFA dated 11/26/14 included EMG upper/lower extremities (results not provided), cervical epidural steroid injection, acupuncture 2X6 to the neck/lower back, and H Wave treatment. The patient was to remain off work for 6 weeks.ODG guidelines Hip & Pelvis chapter under X-ray: "Recommended. Plain radiographs (X-Rays) of the pelvis should routinely be obtained in patients sustaining a severe injury. (Mullis, 2006) X-Rays are also valuable for identifying patients with a high risk of the development of hip osteoarthritis."The treater does not provide a rationale for the requested hip X-ray. Review of medical records does not show a prior hip X-ray. Given the patient's persistent Hip pain, ruling out hip joint osteoarthritis appear reasonable. The request IS medically necessary.

X ray of the left hip: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines- Hip & Pelvis.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Hip & Pelvis chapter, X-ray.

Decision rationale: The patient presents with complaints of bilateral hip and low back pain that radiates to the left foot. The request is for X RAY OF THE LEFT HIP. The RFA provided is

dated 12/29/14. Patient's diagnosis included lumbar spine strain and bilateral hip strain. Physical examination findings were not provided. Per the UR letter dated 01/28/15, the RFA dated 11/26/14 included EMG upper/lower extremities (results not provided), cervical epidural steroid injection, acupuncture 2X6 to the neck/lower back, and H Wave treatment. The patient was to remain off work for 6 weeks.ODG guidelines Hip & Pelvis chapter under X-ray: "Recommended. Plain radiographs (X-Rays) of the pelvis should routinely be obtained in patients sustaining a severe injury. (Mullis, 2006) X-Rays are also valuable for identifying patients with a high risk of the development of hip osteoarthritis."The treater does not provide a rationale for the requested hip X-ray. Review of medical records does not show a prior hip X-ray. Given the patient's persistent Hip pain, ruling out hip joint osteoarthritis appear reasonable. The request IS medically necessary.