

Case Number:	CM15-0089856		
Date Assigned:	05/14/2015	Date of Injury:	07/16/2012
Decision Date:	07/03/2015	UR Denial Date:	05/07/2015
Priority:	Standard	Application Received:	05/11/2015

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, Hawaii
 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 54 year old female patient who sustained an industrial injury on 07/16/2012. The injury was described as the patient having his arm stuck in a door. A primary treating office visit dated 09/18/2014 reported the patient with subjective complaint of having headaches, dizziness, tension, nervousness, buzzing in ears, tension from light, depression, fatigue, stress and sleeping problems, shingles, chest pain, shortness of breath and stomach upsets, history of liver problems, neck pain and stiffness, upper, middle and low back pain, left shoulder and right arm pain, left wrist and right hand pain, and tingling, and numbness of bilateral hands. Objective findings showed hypertonicity and muscle spasm over the cervical, thoracic, and lumbar paravertebral muscles extending from C3-C7 and T1-2, T5-S1; hypertonicity and muscle spasms over bilateral shoulders; weakness of bilateral hands, positive Phalen's; and tenderness over bilateral TMJ's with deviation and clicking of the jaw upon opening and closing. The following diagnoses are applied: cervical myofascitis secondary to continuous strain, rule out disc injuries; thoracolumbar myofascitis secondary to continuous strain, rule out disc injuries; bilateral shoulder and arm myofascitis secondary to continuous strain, rule out internal derangement of the left shoulder, rule out impingement; bilateral wrist and forearm myofascitis secondary to continuous strain, rule out neuropathies of upper extremities, and bilateral TMJ dysfunction, rule out internal derangement. The plan of care noted the patient feeling relief from conservative treatment, therefore, continue with physical therapy, chiropractic, and acupuncture therapies, attend a psychological evaluation, internal medicine checkup regarding chest pain, neurological consultation for headaches, dental

consultation addressing the TMJ, undergo a magnetic resonance imaging study of cervical, lumbar and left shoulder, and follow up visit. She is to return to modified work duty. The patient did undergo a magnetic resonance imaging study on 10/19/2013 of the left shoulder that revealed infraspinatus tendinosis; subchondral cysts within the humeral head, and no other significant findings. In addition, a MRI of the cervical spine revealed C4-5 central focal disc protrusion about the thecal sac; C5-6 broad-based disc protrusion that abuts the spinal cord producing spinal canal narrowing combined with facet and uncinated arthropathy, there is bilateral neuroforaminal narrowing; C6-7 central focal disc protrusion that abuts the thecal sac; straightening of the cervical lordosis which may be due to myospasm, and no other significant findings. By 02/07/2015 the patient had no change in her subjective complaints, objective findings, diagnoses, or plan of care.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy 1 x 6 weeks to the left wrist and left shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines physical medicine Page(s): 99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine Page(s): 98-99.

Decision rationale: The patient presents with pain affecting the neck, upper back, mid back, low back, left shoulder and left upper extremity. The current request is for Physical therapy 1 x 6 weeks to the left wrist and left shoulder. The treating physician report dated 4/9/15 (12B) states, She feel [sic] temporary relief with conservative treatments, therefore she is to continue PT 1 x wk for 6 wks, chiropractic care and acupuncture treatments once a wk for 6 wks to improve mobility, relief [sic] pain and restore function. The MTUS guidelines only provide a total of 8-10 sessions and the patient is expected to then continue with a home exercise program. The medical reports provided, show the patient has received an unknown quantity of physical therapy previously, and her status is not post-surgical. In this case, the patient has received an unknown number of visits of physical therapy to date, so it is unclear if the current request of 6 visits exceeds the recommendation of 8-10 visits as outlined by the MTUS guidelines on page 99. Furthermore, there was no rationale by the physician in the documents provided as to why the patient requires treatment above and beyond the MTUS guidelines. The current request is not medically necessary.

Chiro 1x6 weeks to the left wrist: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58-60.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58.

Decision rationale: The patient presents with pain affecting the neck, upper back, mid back, low back, left shoulder and left upper extremity. The current request is for Chiro 1 x 6 weeks to the left wrist. The treating physician report dated 4/9/15 (12B) states, She feel temporary relief with conservative treatments, therefore she is to continue PT 1 x wk for 6 wks, chiropractic care and acupuncture treatments once a wk for 6 wks to improve mobility, relief[sic] pain and restore function. The MTUS guidelines state that manual manipulation of the wrist is not recommended. In this case, the current request does not satisfy the MTUS guidelines, as chiropractic treatment of the wrist is not supported. The current request is not medically necessary.

MRI of the left wrist: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Online, Forearm, Wrist & Hand, MRI's.

Decision rationale: The patient presents with pain affecting the neck, upper back, mid back, low back, left shoulder and left upper extremity. The current request is for Physical therapy 1x6 weeks to the left wrist and left shoulder. The treating physician report dated 4/9/15 (12B) states, MRI studies of the C/S, L/S and left shoulder are recommended to R/O or confirm underlying injuries. The MTUS guidelines recommend MRI's of the wrist if certain criteria is met. The medical reports provided, do not show that the patient has had a previous MRI of the left wrist. In this case, the patient does present with left wrist pain, but there is no discussion or evidence that the patient experienced trauma to the wrist. Furthermore, the MTUS guidelines require normal radiographs in conjunction with chronic wrist pain in order to support an MRI and the documents provided do not show that the patient has received an X-ray of the left wrist. The current request does not satisfy the ODG guidelines as outlined in the Forearm, Wrist and Hand chapter. The current request is not medically necessary.

Extra corporeal shock wave every 3 months (left wrist/shoulder): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder (updated 04/03/15).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG online, Shoulder, Extracorporeal shock wave therapy (ESWT).

Decision rationale: The patient presents with pain affecting the neck, upper back, mid back, low back, left shoulder and left upper extremity. The current request is for Extra corporeal shock wave every 3 months (left wrist/shoulder). The treating physician report dated 4/9/15 (12B) states, I am recommending shock wave therapy (97799) for her left shoulder and cervical spine to relief [sic] the pain and restore function. The MTUS guidelines do not address the current request. The ODG guideline state the following regarding ESWT of the shoulder:

Recommended for calcifying tendinitis but not for other shoulder disorders. The guidelines go on to state, Maximum of 3 therapy sessions over 3 weeks. In this case, there is no documentation that the patient presents with calcifying tendinitis in the medical reports provided for review. Furthermore, the current request does not specify an exact quantity of sessions of ESWT to be received by the patient and the ODG guidelines only support a maximum of 3 sessions. The current request does not satisfy the ODG guidelines as outlined in the shoulder chapter. The current request is not medically necessary.