

Case Number:	CM14-0111658		
Date Assigned:	08/01/2014	Date of Injury:	10/11/2013
Decision Date:	09/26/2014	UR Denial Date:	06/26/2014
Priority:	Standard	Application Received:	07/17/2014

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, has a subspecialty in Interventional Spine 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 43 year old female with an injury date of 10/11/13. The 06/19/14 report by ■■■■■ states that the patient presents with right shoulder pain rated constant and moderate and right elbow pain rated moderate with use. Right wrist pain is less through use of a wrist support. She also presents with a weak right hand with numbness in the middle finger and intermittent neck pain. She has occasional headaches 1x/week lasting all day. The patient also presents with low back pain rated 7/10 down from 9/10 and chronic hip pain. The treater notes he does not agree with ■■■■■ evaluation the patient can work with restrictions. Examination reveals tenderness to palpation cervical spine, lumbar spine, right wrist, elbow and shoulder. The patient wears a right wrist support. The patient's diagnoses include: 1. Right shoulder sprain/strain 2. Lateral epicondylitis right elbow 3. Tenosynovitis right wrist 4. Cervical sprain/strain 5. Lumbar sprain/strain 6. Radicular neuralgia left leg. The utilization review being challenged is dated 06/26/14. Treatment reports were provided from 02/08/14 to 07/19/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy for the right shoulder, right elbow and right wrist: 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
PHYSICAL MEDICINE Page(s): 98-99.

Decision rationale: The patient presents with lower back pain rated 7/10. She also presents with constant moderate pain to the right shoulder, moderate pain with use to the right elbow and right wrist pain, a weak right hand, chronic hip pain and all day headaches 1x/week. The treater requests for physical therapy for the right shoulder, right elbow and right wrist 12 sessions (2x6 weeks). The 06/26/14 utilization review modifies the treater's request to 10 sessions (2 x 5 weeks). MTUS guidelines pages 98, 99 state that for myalgia and myositis, 9-10 visits are recommended over 8 weeks. For neuralgia, neuritis, and radiculitis, 8-10 visits are recommended. The reports provided show no discussion by the treater why 12 additional sessions are needed to obtain objective functional improvement for this patient. Furthermore, 12 sessions exceeds the 10 allowed per MTUS above. Recommendation is for denial.

Shockwave Treatment to the right shoulder and right wrist: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) ODG guidelines has the following regarding ESWT for shoulder problems.

Decision rationale: The patient presents with pain to the lower back rated 7/10. She also presents with constant moderate pain to the right shoulder, moderate pain with use to the right elbow and right wrist pain, a weak right hand, chronic hip pain and all day headaches 1x/week. The treater requests for Shockwave treatment for the right shoulder and right wrist. Extracorporeal shockwave treatment is a shock treatment indicated for such conditions as calcific tendinitis of shoulder, epicondylitis and plantar fasciitis per ODG guidelines. The reports provided, including the 01/12/14 MRI of the right shoulder and the 01/26/14 MRI of the right wrist, show no discussion or diagnosis of calcific tendinitis of the right shoulder or the right wrist. The ODG guidelines above do not recommend this treatment; therefore, recommendation is for denial.