

Case Number:	CM14-0176696		
Date Assigned:	12/15/2014	Date of Injury:	05/15/2013
Decision Date:	01/15/2015	UR Denial Date:	09/27/2014
Priority:	Standard	Application Received:	10/24/2014

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 38 year old male with an injury date on 05/15/2013. Based on the 09/08/2014 illegible hand written progress report provided by the treating physician, the diagnoses are: 1. Headaches 2. Cervical spine-spondylosis /MLPB with stenosis/ NFN 3. Right shoulder intermittent, tendinitis 4. Right elbow lateral epicondylitis 5. Both wrist- left ulnar/radial neuropathy, R- CTS (right carpal tunnel syndrome). According to this report, the patient complains of cervical spine pain at 6/10, right shoulder/ elbow pain at 7/10, and bilateral wrist pain at 7-8/10. Patient's subjective complaints indicate "Increase pain with cold air/AC; decrease pain with cream as needed. Numbness and tingling are noted are the bilateral wrist and hands." Objective findings indicate tenderness at the upper trap and SCM (sternocleidomastoid). Range of motion of the cervical spine and right shoulder is limited. The 08/04/2014 report indicates "radiating pain from right side of neck to right shoulder." Tinel's test is positive. There were no other significant findings noted on this report. The utilization review denied the request for (1) Ortho referral for the right shoulder and right elbow, (2) Neurosurgeon consultation for the neck and the right wrist, (3) 7 NIOSH, and (4) 3 Shockwave visits for the right shoulder, right elbow, neck and right wrist on 09/27/2014 based on the MTUS/ODG guidelines. The requesting physician provided treatment reports from 02/17/2014 to 12/08/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ortho referral for the right shoulder and right elbow: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 10 Elbow Disorders (Revised 2007) Page(s): 196, 209-210, 2, 4, and 15.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Ch.: 7 page 127, referral.

Decision rationale: According to the 09/08/2014 requesting report, this patient presents with cervical spine pain at 6/10, right shoulder/ elbow pain at 7/10, and bilateral wrist pain at 7-8/10. The current request is for an orthopedic referral for the right shoulder and right elbow. The ACOEM Guidelines Chapter 7, page 127 state that the occupational health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. A referral may be for consultation to aid in the diagnosis, prognosis, therapeutic management, determination of medical stability, and permanent residual loss and/or the examinee's fitness for return to work. The current request is supported by the ACOEM guidelines for specialty referral. The treating physician feels that additional expertise including surgery may be required. The request is medically necessary.

Neurosurgeon consultation for the neck and the right wrist: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270, 18.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Ch.: 7 page 12, consultation.

Decision rationale: According to the 09/08/2014 requesting report, this patient presents with cervical spine pain at 6/10, right shoulder/ elbow pain at 7/10, and bilateral wrist pain at 7-8/10. The current request is for Neurosurgeon consultations for the neck and the right wrist. Regarding consultations, ACOEM states that the occupational health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. Review of available report shows no discussion or significant exam findings of the right shoulder and right elbow for the needs of surgery. The treating physician does not mention planned surgeries or explanation in regards to necessity of Neurosurgeon consultations. The request is not medically necessary.

7 NIOSH: 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.

Decision rationale: According to the 09/08/2014 requesting report, this patient presents with cervical spine pain at 6/10, right shoulder/ elbow pain at 7/10, and bilateral wrist pain at 7-8/10. The current request is for 7 NIOSH. The Utilization review denial letter states "The National Institute for Occupational Safety and Health (NIOSH) testing, there are no specific guidelines to support this form of testing as a separate assessment than what is already including in the physical exam component of every level of E/M service." In this case, there are no current available guidelines to support the requested 7 NIOSH. Per MTUS guidelines, the treating physician must monitor the patient and provide appropriate treatment recommendations. NIOSH is part and parcel of a physical examination. There is no need for any additional specialized testing. The request is not medically necessary.

3 Shockwave visits for the right shoulder, right elbow, neck and right wrist: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 10 Elbow Disorders (Revised 2007) Page(s): 203, 29. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), shoulder (acute & chronic)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) shoulder chapter under shockwave therapy and shoulder chapter under shockwave therapy.

Decision rationale: According to the 09/08/2014 requesting report, this patient presents with cervical spine pain at 6/10, right shoulder/ elbow pain at 7/10, and bilateral wrist pain at 7-8/10. The current request is for 3 Shockwave visits for the right shoulder, right elbow, neck and right wrist. MTUS does not discuss ESWT for the shoulder, however ODG guidelines does discuss ESWT, "Extracorporeal shock wave therapy (ESWT) has been suggested to be an effective treatment option for treating calcific tendinitis of the shoulder before surgery, but after conservative treatments, including physical therapy, iontophoresis, deep friction, local or systemic application of noninflammatory drugs, needle irrigation-aspiration of calcium deposit, and subacromial bursal steroid injection." In this case, the treating physician did not provide documentation of "calcific tendinitis" of the shoulder. No documentations of conservative treatments, including physical therapy, iontophoresis or deep friction were found in the medical records provided. The requested shockwave therapy for the bilateral shoulder and wrist are not in accordance with ODG guidelines. Therefore, the request is not medically necessary.