

<b>Case Number:</b>	CM15-0003924		
<b>Date Assigned:</b>	02/13/2015	<b>Date of Injury:</b>	10/16/2014
<b>Decision Date:</b>	05/13/2015	<b>UR Denial Date:</b>	12/31/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/08/2015

### 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, Arizona

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 34-year-old male who reported a cumulative trauma injury on 10/16/2014. The current diagnoses include post-traumatic stress disorder, cervical spine sprain, bilateral shoulder sprain, left forearm second-degree burn, thoracic sprain and lumbar sprain. The only physician progress note submitted for review is documented on 10/30/2014. It was noted that the injured worker sustained a cumulative trauma injury from 02/18/2013 through 10/16/2014. The injured worker presented with multiple complaints to include anxiety, attention, insomnia, neck pain, mid back pain, bilateral shoulder pain and left forearm pain. Upon examination, there was tenderness and spasm over the upper trapezium, paravertebral musculature and interscapular area bilaterally. Range of motion of the cervical spine was painful and restricted. Examination of the bilateral shoulder also revealed positive tenderness to palpation with painful and restricted range of motion. The examination of the left forearm revealed skin discoloration over the dorsal aspect. The injured worker had a normal gait and did not use assistive devices for ambulation. Examination of the lumbar spine revealed positive tenderness with muscle spasm and painful/restricted range of motion. There were no treatment recommendations provided on that date. It was noted that the injuries arose out of and occurred in the course of the injured worker's normal employment. The injured worker's problems to the neck, shoulders, left forearm, mid and low back were attributed entirely to the injury on 10/12/2014 and cumulative trauma from 02/18/2013 through 10/16/2014. There was no Request for Authorization form submitted for review.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Solar Care or Cane (Please Specify): Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg chapter, Walking Aid.

**Decision rationale:** The Official Disability Guidelines state walking aids may be necessary as indicated. In this case, the provider noted the injured worker did not utilize assistive devices for ambulation and noted a normal gait. There was no documentation of lower extremity weakness or instability. The medical necessity for the requested durable medical equipment has not been established. Therefore, the request is not medically appropriate.

### **Medications (Unspecified Name/Dosage/Quantity): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 195-196.

**Decision rationale:** The California MTUS/ACOEM Practice Guidelines state a relief of discomfort can be accomplished most safely by activity modification and systemic nonprescription analgesics. The specific type of medication was not listed in the request. There was also no strength, frequency or quantity listed in the request. As such, the request is not medically appropriate.

### **Shockwave Therapy Bilateral Shoulders (Unspecified Frequency/Duration): Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 201-205.

**Decision rationale:** The California MTUS/ACOEM Practice Guidelines state there is medium quality evidence to support manual physical therapy, ultrasound therapy and high energy extracorporeal shockwave therapy for calcifying tendinitis of the shoulder. In this case, the injured worker does not maintain a diagnosis of calcifying tendinitis of the bilateral shoulders. There is also no specific frequency or duration of treatment listed in the request. As such, the request is not medically appropriate at this time.

**MRI (Unspecified Body Part): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-209.

**Decision rationale:** California MTUS/ACOEM Practice Guidelines state for most patients with shoulder problems, special studies are not needed unless a 4 to 6 week period of conservative care and observation fails to improve symptoms. The request as submitted failed to indicate a specific body part to be treated. There was no evidence of an exhaustion of conservative treatment prior to the request for an imaging study. The medical necessity has not been established. As such, the request is not medically appropriate.