MAXIMUS Federal Services

Case Number:	CM15-0173031		
Date Assigned:	09/15/2015	Date of Injury:	09/29/2012
Decision Date:	10/14/2015	UR Denial Date:	08/12/2015
Priority:	Standard	Application Received:	09/02/2015

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, Oregon, Washington
Certification(s)/Specialty: Orthopedic Surgery

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 (IW) is a 51-year-old male who sustained an industrial injury on 09-29-2012. The injured workers diagnoses are : Status post right shoulder surgery 02-02-2015, Refractory range of motion, right shoulder, Cervical spondylosis, Cervical radiculopathy, right lumbar radiculopathy, electro diagnostically positive, Lumbar myofascial pain, Closed head injury, and adhesive capsulitis , right shoulder. Treatment to date has included right shoulder surgery 02-02-2015 physical therapy x12 sessions and hydrocodone 10 mg daily. Currently, the injured worker complains of pain in the right shoulder that he rates as a 7 on a scale of 0-10, low back pain rated a 6 on a scale of 0-10, cervical and left wrist pain that he rates as a 5 on a scale of 0-10. On exam, there are no signs of infection on the right shoulder. Flexion is 90 degrees, external rotation 40 degrees, internal rotation 40 degrees, and there is atrophy to the right deltoid musculature with 4 out of 5 strength in the right deltoid. There is tenderness to palpation of the lumbar and cervical spine. Lumbar range of motion is flexion 50 degrees, extension 40 degrees, left and right lateral tilt 40 degrees, left and right rotation 40 degrees. He has a positive straight leg raise on the left that elicits pain to the foot at 45 degrees, and right 35 degrees. He has decreased sensation right greater than left L5 and S1 dermatomal distributions, and the right external hallucis longus (EHL) tendon, 4+5 and right eversion 4+5. His cervical range of motion has Flexion 50 degrees, extension 45 degrees, left and right rotation 45 degrees, left and right lateral tilt 35 degrees. He has diminished sensation right greater than left C6 and C7 dermatomal distribution. His left wrist is unchanged. The worker continues to be off work. The plan is for avoiding further aggressive options. His recent physical therapy diminished pain and improved

tolerance to activity. Additional 8 sessions requested with emphasis on active therapy. The worker is noted to have a decline in tolerance to sitting. A MRI is requested due to gradual crescendo lower extremity neurologic exam. Hydrocodone will be continued. A request for authorization was submitted for: Additional Post-Op PT 2x4 Right Shoulder, Shockwave Therapy 3 Sessions Right Shoulder, and a MRI Lumbar Spine. A utilization review decision (08-12-2015) non-certified the request in its entirety.

IMR ISSUES, DECISIONS AND RATIONALES

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

Additional Post-Op PT 2x4 Right Shoulder: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment 2009, Section(s): Shoulder.

Decision rationale: Per the CA MTUS Post Surgical Treatment Guidelines, Shoulder, page 26-27 the recommended amount of postsurgical treatment visits allowable are: Rotator cuff syndrome/Impingement syndrome (ICD9 726.1; 726.12): Postsurgical treatment, arthroscopic: 24 visits over 14 weeks, Postsurgical physical medicine treatment period: 6 months. The guidelines recommend "initial course of therapy" to mean one half of the number of visits specified in the general course of therapy for the specific surgery in the postsurgical physical medicine treatment recommendations set forth in the guidelines. In this case, the claimant has been seen by PT 12 times. The requested 8 visits is still within the number of allowed visits per CA MTUS guidelines. Therefore, the determination is medically necessary.

Shockwave Therapy 3 Sessions Right Shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder section.

Decision rationale: Per ODG:"Criteria for the use of Extracorporeal Shock Wave Therapy (ESWT):1) Patients whose pain from calcifying tendinitis of the shoulder has remained despite six months of standard treatment.2) At least three conservative treatments have been performed prior to use of ESWT. These would include: a. Rest, b. Ice, c. NSAIDs, d. Orthotics, e. Physical Therapy, e. Injections (Cortisone).3) Contraindicated in Pregnant women; Patients younger than 18 years of age; Patients with blood clotting diseases, infections, tumors, cervical compression, arthritis of the spine or arm, or nerve damage; Patients with cardiac pacemakers; Patients who had physical or occupational therapy within the past 4 weeks; Patients who received a local steroid injection within the past 6 weeks; Patients with bilateral pain; Patients who had previous surgery for the condition. 4) Maximum of 3 therapy sessions over 3

weeks."Due to the lack of evidence supporting the use of this treatment modality and the lack of a diagnosis of calcific tendonitis the recommendation is not medically necessary.

MRI Lumbar Spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Initial Assessment, Special Studies.

Decision rationale: According to CA MTUS/ (ACOEM), 2nd edition (2004), page 303, Low Back Complaints, Chapter 12, which is part of the California Medical Treatment Utilization Schedule. It states, "Unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Indiscriminant imaging will result in false-positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant surgery. If physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, computer tomography [CT] for bony structures)."In this particular patient, there is no indication of criteria for an MRI based upon physician documentation or physical examination findings from the exam notes provided. There is no documentation nerve root dysfunction or failure of a treatment program such as physical therapy. Therefore, the request of the MRI of the lumbar spine is not medically necessary and appropriate and is not medically necessary.