

Case Number:	CM13-0024599		
Date Assigned:	07/02/2014	Date of Injury:	11/14/2007
Decision Date:	09/08/2014	UR Denial Date:	08/16/2013
Priority:	Standard	Application Received:	09/16/2013

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 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:

According to the records made available for review, this is a 34-year-old female with a 11/14/07 date of injury. At the time (8/16/13) of request for authorization for physical therapy right upper extremity (URE) three times a week x four weeks, MRI cervical spine, and MRI right shoulder, there is documentation of subjective (neck pain, pain that travels to the shoulder/arm down to the hand and fingers, associated numbness in the shoulder/arm; right shoulder pain, popping, clicking, and grinding sensation in the shoulder, pain with movements above shoulder level, difficult sleeping and patient awoken with pain and discomfort) and objective (cervical spine paravertebral muscle tenderness, spasm, reduced sensation in the right median nerve distribution, positive Phalen's and Tinel's, normal motor strength, 2+ deep tendon reflexes, and decreased range of motion; shoulder decreased range of motion and positive impingement) findings, current diagnoses (cervical spine strain, right shoulder impingement syndrome, right lateral epicondylitis, and right carpal tunnel syndrome), and treatment to date (activity modification, acupuncture, medications, chiropractic, and physical therapy). 7/18/13 medical report identifies the patient had an MRI of the neck in January of 2013. The number of physical therapy visits cannot be determined. Regarding the requested physical therapy right upper extremity (URE) three times a week x four weeks, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services as a result of physical therapy completed to date and a statement of exceptional factors to justify going outside of guideline parameters. Regarding the requested MRI cervical spine, there is no documentation of a diagnosis/condition (with supportive subjective/objective findings) for which a repeat study is indicated. Regarding the requested MRI right shoulder, there is no documentation of plain radiographs findings.

IMR ISSUES, DECISIONS AND RATIONALES

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

PHYSICAL THERAPY RIGHT UPPER EXTREMITIES (URE) THREE TIMES A WEEK X FOUR WEEKS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines physical medicine Page(s): 98. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Elbow, Carpal Tunnel Syndrome, Physical Therapy (PT).

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines support a brief course of physical medicine for patients with chronic pain not to exceed 10 visits over 4-8 weeks with allowance for fading of treatment frequency, with transition to an active self-directed program of independent home physical medicine/therapeutic exercise. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. ODG recommends a limited course of physical therapy for patients with a diagnosis of impingement syndrome not to exceed 10 visits over 8 weeks. In addition, ODG recommends a limited course of physical therapy for patients with a diagnosis of lateral epicondylitis not to exceed 8 visits over 5 weeks. Furthermore, ODG recommends a limited course of physical therapy for patients with a diagnosis of carpal tunnel syndrome not to exceed 1-3 visits over 3-5 weeks. ODG also notes patients should be formally assessed after a "six-visit clinical trial" to see if the patient is moving in a positive direction, no direction, or a negative direction (prior to continuing with the physical therapy) and when treatment requests exceeds guideline recommendations, the physician must provide a statement of exceptional factors to justify going outside of guideline parameters. Within the medical information available for review, there is documentation of cervical spine strain, right shoulder impingement syndrome, right lateral epicondylitis, and right carpal tunnel syndrome. In addition, there is documentation of previous physical therapy treatments. However, there is no documentation of the number of physical therapy visits completed to date and, if the number of treatments have exceeded guidelines, remaining functional deficits that would be considered exceptional factors to justify exceeding guidelines. In addition, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services as a result of physical therapy completed to date. Furthermore, given that the request is for physical therapy right upper extremity (URE) three times a week x four weeks, there is no documentation of a statement of exceptional factors to justify going outside of guideline parameters. Therefore, based on guidelines and a review of the evidence, the request for physical therapy right upper extremity (URE) three times a week x four weeks is not medically necessary.

MRI CERVICAL SPINE: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 179-183. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Official Disability Guidelines (ODG) Minnesota Rules, 5221.6100 Parameters for Medical Imaging.

Decision rationale: MTUS reference to ACOEM Guidelines identifies documentation of red flag diagnoses where plain film radiographs are negative, physiologic evidence (in the form of definitive neurologic findings on physical examination, electrodiagnostic studies, laboratory tests, or bone scans) of tissue insult or neurologic dysfunction, failure of conservative treatment; or diagnosis of nerve root compromise, based on clear history and physical examination findings, in preparation for invasive procedure; as criteria necessary to support the medical necessity of an MRI. ODG identifies documentation of a diagnosis/condition (with supportive subjective/objective findings) for which a repeat study is indicated (such as: To diagnose a suspected fracture or suspected dislocation, to monitor a therapy or treatment which is known to result in a change in imaging findings and imaging of these changes are necessary to determine the efficacy of the therapy or treatment (repeat imaging is not appropriate solely to determine the efficacy of physical therapy or chiropractic treatment), to follow up a surgical procedure, to diagnose a change in the patient's condition marked by new or altered physical findings) as criteria necessary to support the medical necessity of a repeat MRI. Within the medical information available for review, there is documentation of cervical spine strain, right shoulder impingement syndrome, right lateral epicondylitis, and right carpal tunnel syndrome. In addition, there is documentation that a previous neck MRI was done 1/13. However, there is no documentation of a diagnosis/condition (with supportive subjective/objective findings) for which a repeat study is indicated. Therefore, based on guidelines and a review of the evidence, the request for MRI cervical spine is not medically necessary.

MRI RIGHT SHOULDER: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 214. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Magnetic resonance imaging (MRI).

Decision rationale: MTUS reference to ACOEM Guidelines identifies documentation of preoperative evaluation of partial thickness or large full-thickness rotator cuff tears, as criteria necessary to support the medical necessity of shoulder MRI. ODG identifies documentation of acute shoulder trauma, suspect rotator cuff tear/impingement; over age 40; normal plain radiographs; subacute shoulder pain, or suspect instability/labral tear, as criteria necessary to support the medical necessity of shoulder MRI. Within the medical information available for review, there is documentation of cervical spine strain, right shoulder impingement syndrome,

right lateral epicondylitis, and right carpal tunnel syndrome. In addition, there is documentation of suspect impingement. However, there is no documentation of plain radiographs findings. Therefore, based on guidelines and a review of the evidence, the request for MRI right shoulder is not medically necessary.