

Case Number:	CM13-0027221		
Date Assigned:	11/22/2013	Date of Injury:	10/12/2010
Decision Date:	01/21/2014	UR Denial Date:	08/29/2013
Priority:	Standard	Application Received:	09/20/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in Illinois. 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 physician 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.

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 58-year-old female who reported an injury on 10/12/2010. The patient is noted to have complaints of neck, shoulder, and hip pain. The patient has previously completed physical therapy and is being treated with Mobic, Flector patch and Omeprazole. The patient has also been recommended for MRI of the right shoulder and right hip. On examination, the patient has right sided cervical paravertebral tenderness, right trapezius tenderness, right shoulder tenderness, positive bilateral impingement tests, 150 degrees of right shoulder abduction, 5/5 motor strength, and diminished sensation in the median nerve distribution bilaterally. The claimant had 45 degrees of right wrist plantar flexion, 65 degrees of dorsiflexion, with tenderness to the bilateral radial styloid, first extensor compartment, carpal tunnel, thenar eminence, and TFCC. The patient also had positive Finkelstein's and Phalen's tests bilaterally with positive Tinel's on the left. The patient was recommended for MR arthrogram of the right shoulder and right wrist with continued physical therapy

IMR ISSUES, DECISIONS AND RATIONALES

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

MR arthrogram of right shoulder: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Guidelines, Forearm, Wrist, and Hand.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

Decision rationale: CA MTUS/ACOEM guidelines state that, "For patients with limitations of activity after four weeks and unexplained physical findings, such as effusion or localized pain (especially following exercise), imaging may be indicated to clarify the diagnosis and assist reconditioning. Imaging findings can be correlated with physical findings." CA MTUS/ACOEM guidelines state that the primary criteria for ordering imaging studies are "Emergence of a red flag (e.g., indications of intra-abdominal or cardiac problems presenting as shoulder problems)...Physiologic evidence of tissue insult or neurovascular dysfunction (e.g., cervical root problems presenting as shoulder pain, weakness from a massive rotator cuff tear, or the presence of edema, cyanosis or Raynaud's phenomenon)...Failure to progress in a strengthening program intended to avoid surgery...Clarification of the anatomy prior to an invasive procedure (e.g., a full thickness rotator cuff tear not responding to conservative treatment)." The documentation submitted for review indicates that the patient has undergone prior MRI of the right shoulder and revealed degeneration with increased signal of the subacromial bursa without rotator cuff tear. The patient also had irregular appearance of the posterior labrum without definite tear. There is lack of submitted documentation to support that the patient had any significant change in symptoms since prior MRI. The patient continues to have tenderness to palpation with positive impingement sign. Given the lack of change in symptoms or effective findings, the need for an MR arthrogram of the right shoulder would not be supported. Furthermore, there is lack of documentation of a positive Obrien's test to support labral pathology to warrant an arthrogram study. Given the above, the request is non-certified.

MR arthrogram of right wrist: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Guidelines, Forearm, Wrist, and Hand. .

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 268-269..

Decision rationale: CA MTUS/ACOEM guidelines state that, "Imaging studies to clarify the diagnosis may be warranted if the medical history and physical examination suggest specific disorders." The documentation submitted for review indicates that the patient has undergone a prior MRI of the right wrist and revealed minimal subcutaneous edema, degenerative changes, and no evidence of TFCC or tendon tear. The documentation submitted for review indicates that the patient has signs and symptoms consistent with bilateral carpal tunnel syndrome. However, there is a lack of significant findings other than tenderness to support the need for an MRI to evaluate underlying pathology. There is no significant change since the prior study to warrant a repeat imaging study of the right wrist. As such, the request is non-certified.

Physical therapy two (2) times per week for four (4) weeks: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Guidelines, Physical Therapy.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Physical Medicine Page(s): 98-99.

Decision rationale: California MTUS Guideline states that, "Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort." Guidelines recommend up to 10 visits of therapy for chronic diagnoses. The documentation submitted for review indicates the patient has been participating in physical therapy long-term. The request for continued therapy would exceed evidence based guidelines for total duration of care. The patient has completed sufficient formal physical therapy to date and should be capable of carrying out a home exercise program at this time. As such, the request is non-certified.