

<b>Case Number:</b>	CM14-0005968		
<b>Date Assigned:</b>	02/07/2014	<b>Date of Injury:</b>	09/10/2013
<b>Decision Date:</b>	07/14/2014	<b>UR Denial Date:</b>	01/13/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/15/2014

### 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 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:

This is a 56-year-old female with a 9/10/13 date of injury. The exact mechanism of injury was not described. On 2/6/14, the patient was noted to have more pain in her left shoulder and is getting physical therapy for her right shoulder. She has less pain in her right thumb but it still triggers. Objective exam: decreased ROM and strength, tenderness to palpation to the left shoulder. Positive Faber's test on the right side. Tenderness to the lumbar spine with decreased ROM. Diagnostic Impression: s/p Rotator Cuff Repair 10/31/13, Lumbar Sprain, Shoulder Injury. Treatment to date: physical therapy x 24 sessions, medication management. A UR decision dated 1/13/14 denied the request for physical therapy since guidelines recommend 24 sessions and the patient has met the recommendations. MRI lumbar spine was denied because no criterion was met for proceeding with a MRI.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**SIXTEEN (16) SESSIONS OF PHYSICAL THERAPY FOR THE RIGHT SHOULDER, NECK, LUMBAR SPINE AND RIGHT HIP: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter: Physical Therapy Guidelines.

**Decision rationale:** Chronic Pain Medical Treatment Guidelines stresses the importance of a time-limited treatment plan with clearly defined functional goals, frequent assessment and modification of the treatment plan based upon the patient's progress in meeting those goals, and monitoring from the treating physician regarding progress and continued benefit of treatment is paramount. Physical Medicine Guidelines - Allow for fading of treatment frequency. However, this patient is documented to have already completed 24 sessions of post-operative physical therapy, and has also been doing physical therapy for the back and hip. It is unclear if she has gained any functional improvement from the prior physical therapy sessions. Guidelines do not support additional physical therapy in the absence of functional benefit. In addition, the number of sessions previously attended in total is not documented, but already exceed guideline recommendations. There is no clear rationale as to why the patient needs physical therapy in excess of the recommended sessions. It is unclear why she has not been able to transition to a successful, independent home exercise program. Therefore, the request for sixteen sessions of Physical Therapy for the right shoulder, neck, lumbar spine, and right hip is not medically necessary.

**MRI FOR THE LUMBAR SPINE:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter: MRI.

**Decision rationale:** Low Back Complaints ACOEM Practice Guidelines supports imaging of the lumbar spine in patients with red flag diagnoses where plain film radiographs are negative; unequivocal objective findings that identify specific nerve compromise on the neurologic examination, failure to respond to treatment, and consideration for surgery. However, there is no documentation of red flags such as weakness or radiculopathy. She is noted to have tenderness on exam with decreased range of motion, but no other significant findings. She is noted to have done physical therapy, but it is unclear what her response to it was. There was no clear documentation of failure of conservative management. There is no plain film radiographs of the lumbar spine noted. Therefore, the request for MRI for the Lumbar Spine is not medically necessary.