MAXIMUS Federal Services

Case Number:	CM14-0007641		
Date Assigned:	02/10/2014	Date of Injury:	05/28/2003
Decision Date:	06/24/2014	UR Denial Date:	01/16/2014
Priority:	Standard	Application Received:	01/21/2014

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, has a subspecialty in Neuromuscular Medicine and is licensed to practice in Maryland. 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:

There is an 8/1/13 orthopedic reevaluation that states that the patient denies shoulder pain at this time and completed physical therapy 3 months ago. She had recent total knee replacement done through [redacted] in June. She is working regular duties. The exam of the left shoulder revealed full range of motion, normal strength, negative provocative testing, normal reflex and sensation. There is an antalgic gait. The knee flexion was 0-120 on the right and 0-100 on the left. The sensation is intact in the legs. The treatment plan includes a home exercise program. There is a 12/16/13 orthopedic office visit where the patient states she was very much improved with her left shoulder and left knee conditions up until the recent change in weather. She complains of increased pain in her left shoulder with the cold weather and a new sensation of popping in her left knee. She denies any new injuries to either body part. She complains of being unable to lie on her left side due to increased pain. On exam there is tenderness around the shoulder and a positive impingement sign. There is full bilateral upper extremity strength, sensation, and reflexes. There is a request for a magnetic resonance imaging (MRI) of the left shoulder to rule out rotator cuff and for physical therapy 2-3 times per week times 4-6 weeks for increased range of motion and strengthening of left knee using all modalities for quad tendonitis.

IMR ISSUES, DECISIONS AND RATIONALES

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

MAGNETIC RESONANCE IMAGING (MRI) LEFT SHOULDER: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation AMERICAN COLLEGE OF OCCUPATIONAL AND ENVIRONMENTAL MEDICINE (ACOEM), 2ND EDITION, (2004) , SHOULDER COMPLAINTS, 207-208

Decision rationale: Magnetic resonance imaging (MRI) of the left shoulder is not medically necessary per the American College of Occupational and Environmental Medicine (ACOEM) California Medical Treatment Utilization Schedule (MTUS) guidelines. The guidelines recommend further imaging with emergence of a red flag, physiologic evidence of neurovascular or tissue insult, cervical root problems presenting as shoulder pain, failure to improve in a strengthening program, or clarification of the anatomy prior to an invasive procedure. The documentation reveals no evidence of red flag conditions. There is full strength on examination. There is no plan for surgery. The request for an MRI of the left shoulder is not medically necessary.

PHYSICAL THERAPY TWO TO THREE TIMES A WEEK FOR FOUR TO SIX WEEKS FOR THE LEFT KNEE: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CHRONIC PAIN MEDICAL TREATMENT GUIDELINES.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines PHYSICAL MEDICINE Page(s): 98-99. Decision based on Non-MTUS Citation CHRONIC PAIN MEDICAL TREATMENT GUIDELINES , PHYSICAL MEDICINE, 98-99

Decision rationale: Physical therapy two to three times a week for four to six weeks for the left knee is not medically necessary. The patient has completed therapy in the past for her knees postoperatively but without documentation of how much therapy and what was done in therapy already it is not possible to certify more. She should be versed in a home exercise program at this point for her knees. The request for physical therapy two to three times a week for four to six weeks is not medically necessary. Furthermore, even if the patient has not had any knee therapy in the past or surgery on her knee the request exceeds the California Medical Treatment Utilization Schedule (MTUS) guideline recommendations for her condition (up to 10 visits) in this case of quadriceps tendonitis.