

<b>Case Number:</b>	CM14-0107271		
<b>Date Assigned:</b>	08/01/2014	<b>Date of Injury:</b>	02/10/2014
<b>Decision Date:</b>	08/29/2014	<b>UR Denial Date:</b>	06/25/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/10/2014

### 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 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 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:

The injured worker is a 50-year-old male who reported an injury on 02/10/2014 due to a lifting injury. On 05/20/2014 the injured worker presented with left shoulder pain. On examination of the left shoulder, there was severe decrease range of motion, pinpoint pain at the supraspinatus attachment into the shoulder, and supraspinatus fossa and scapula. There was hypertonicity to the left pectoralis muscle, left biceps tendon, and bilateral trapezius muscles. The range of motion values for the cervical spine were 20 degrees of flexion, 5 degrees of extension, 10 degrees of left lateral flexion, 15 degrees of right lateral flexion, 25 degrees of left rotation, and 15 degrees of right rotation. The range of motion values for the left shoulder revealed 90 degree of flexion, 5 degrees of extension, 40 degrees of lateral rotation, 5 degrees of medial rotation, 40 degrees of abduction, and 10 degrees of adduction. MRI of the left shoulder noted a near full thickness tear of the supraspinatus tendon within 7 mm of its insertion and mild to moderate impingement on the supraspinatus musculotendinous junction. Diagnoses were supraspinatus tear of the left, cervicobrachial syndrome, shoulder pain to the right, and thoracalgia. Prior therapy included physical therapy and medications. The provider recommended physical therapy, a home cervical traction, cervical MRI, and chiropractic treatment. The provider's rationale was not provided. The request for authorization form was not included in medical documents for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical Therapy Twelve (12) Visits Left Shoulder: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Shoulder (updated 3/31/2014), Physical Therapy.

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

**Decision rationale:** The request for physical therapy 12 visits for the left shoulder is non-certified. The California MTUS state that active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. Injured workers are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. The guidelines recommend up to 10 visits of physical therapy for up to 4 weeks. There was a lack of documentation indicating the injured worker's prior request for physical therapy as well as the efficacy of the prior therapy. The amount of physical therapy visits that have already been completed was not provided. Additionally, injured workers are instructed and expected to continue active therapies at home as an extension of the treatment process and there are no significant barriers to transitioning the injured worker to an independent home exercise program. The provider's request for 12 visits of physical therapy exceed the guideline recommendations. The provider's request did not indicate the frequency of the physical therapy visits in the request that was submitted. As such, this request is not medically necessary.

**Home Cervical Traction:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 181.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173.

**Decision rationale:** The request for a home cervical traction is non-certified. The California MTUS/ACOEM guidelines state there is no high-grade scientific evidence to support the effectiveness of ineffectiveness of passive physical modalities such as traction. Emphasis should be focused on functional restoration and return of injured worker's activities to normal daily living. As the guidelines state that there is no high-grade scientific evidence to support passive modalities, traction would not be warranted. Additionally, the provider's request did not indicate whether the home cervical traction device was to be purchased or rented in the request as submitted. As such, the request is not medically necessary.

**Cervical Magnetic Resonance Imaging (MRI):** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

**Decision rationale:** The request for a cervical magnetic resonance imaging (MRI) is non-certified. In the California MTUS/ACOEM guidelines state for most injured workers presenting with true neck or upper back problems, special services are not needed unless for 3 to 4 week period of conservative and conservation fails to improve symptoms. The criteria for ordering imaging studies include emergency preventative flag, physiologic evidence of tissue insult of neurologic dysfunction, failure to progress in a strengthening program intended to avoid surgery, and clarification of anatomy prior to an invasive procedure. There is lack of evidence in the medical documents presented of an emergence of a red flag or physiologic evidence of tissue insult of neurologic dysfunction. There is lack of evidence of a 3 to 4 week period of failure to respond to conservative care and lack of evidence of a failure to progress in a strengthening program intended to avoid surgery. The provider's rationale for cervical MRI was not provided. As such, this request is not medically necessary.

**Chiropractic two (2) times a week for six (6) weeks:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Neck and Upper Back (updated 5/30/2014), Manipulation.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine, page(s) 58 Page(s): 58.

**Decision rationale:** The request for chiropractic 2x a week for 6 weeks is non-certified. The California MTUS guidelines state that chiropractic care for chronic pain if caused by musculoskeletal conditions is recommended for the intended goal or effect of modern medicine is the achievement of positive, symptomatic, or objective medical gains in functional improvement to facilitate progression in the injured worker's therapeutic exercise program and return to productive activities. The recommended chiropractic trial of 6 visits over 2 weeks, and with evidence of functional improvement, 12 to 18 visits over 6 to 8 weeks. The provider's request for chiropractic care 2x a week for 6 weeks does not indicate the site that the chiropractic care is intended for in the request submitted. As such, this request is not medically necessary.