

<b>Case Number:</b>	CM14-0108040		
<b>Date Assigned:</b>	08/01/2014	<b>Date of Injury:</b>	03/07/2014
<b>Decision Date:</b>	09/10/2014	<b>UR Denial Date:</b>	06/16/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/11/2014

### 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 & Rehabilitation and is licensed to practice in Texas and Oklahoma. 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 52-year-old male who reported an injury on 03/07/2014 due to a fall from scaffolding. The injured worker has been diagnosed with status post fall, left rib fractures 1 and 2, face contusion, nondisplaced fracture of the left zygomatic arch, nondisplaced fracture of left orbital roof, nondisplaced fracture of lateral wall of the left orbit, traumatic brain injury (hemorrhagic contusion, SDH), SAD, and abdominal wall contusion. The injured worker received multiple CT scans and x-rays while in the hospital from 03/07/2014 to 03/10/2014. A CT scan, which included the shoulder in addition to a shoulder plain film, showed no evidence of primary shoulder problems. On 04/22/2014, the injured worker reported persistent pain and limited range of motion to the left shoulder. Bilateral peripheral extremities indicated no clubbing, cyanosis, or edema. There was mild tenderness over the left acromion with painful flexion and external rotation. The physician also noted motor strength to the peripheral extremities bilaterally indicated both as normal. Function was normal and motor strength was grossly normal. Strength was normal in all limbs with no abnormal movements. In the clinical note dated 05/14/2014, the injured worker reported complaints of significant pain and discomfort in his right shoulder. He stated that his shoulder was not treated during hospitalization. He denied any overt weakness of his arms, but has limited range of motion in the right shoulder. The physician noted normal strength throughout with normal sensory exam. Normal turning and arm swing was noted. The provider noted some tenderness at the acromioclavicular joint. He had reasonably good range of motion with some limitation in abduction and external rotation. The physician started the injured worker on Topiramate and the injured worker was taking ibuprofen as needed. The physician's treatment plan included recommendations for a repeat cranial CT scan without contrast, an MRI of the brain with and without contrast to further evaluate vertigo, an MRI of the left shoulder to rule out ligament or rotator cuff injury, and physical therapy and

occupational therapy initiation. The physician was requesting occupational therapy 15 visits for the left shoulder and Magnetic Resonance Imaging of the left shoulder in order to further the process to return range of motion to the left shoulder and for consideration of possible future surgery. A Request for Authorization form was signed on 04/22/2014.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Occupational therapy 15 visits for the left shoulder.: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 114. Decision based on Non-MTUS Citation ODG: <http://www.odg-twc.com/preface.htm#physicaltherapyguidelines>.

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

**Decision rationale:** The request for Occupational therapy 15 visits for the left shoulder is non-certified. The California MTUS Guidelines note 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. The guidelines recommend allowing for fading of treatment frequency from up to 3 visits per week to 1 or less with a self-directed home physical medicine. The guidelines recommend 8 to 10 visits over 4 weeks. The physician notes normal strength to the bilateral upper extremities. The provider noted some tenderness at the acromioclavicular joint and reasonably good range of motion with some limitation in abduction and external rotation. Within the provided documentation the requesting physician did not provide a recent complete assessment of the injured worker's objective functional condition with quantifiable measures in order to demonstrate deficits for which therapy would be indicated. The physician request for 15 visits would exceed the guideline recommendations. As such, the request is non-certified.

#### **Magnetic Resonance Imaging of the left 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): 207-209.

**Decision rationale:** The request for Magnetic Resonance Imaging of the left shoulder is non-certified. California ACOEM Guidelines under shoulder complaints covering diagnostic studies authorizes use of MRIs after conservative care and therapy have failed. The physician notes normal strength to the bilateral upper extremities. The provider noted some tenderness at the acromioclavicular joint and reasonably good range of motion with some limitation in abduction and external rotation. There is a lack of documentation indicating the injured worker has significant functional deficits and positive provocative testing to indicate the need for an MRI of

the left shoulder. Additionally, there is no indication that the injured worker has completed an adequate course of physical or occupational therapy. As such, the request is non-certified.