

Case Number:	CM14-0013538		
Date Assigned:	05/14/2014	Date of Injury:	09/07/2007
Decision Date:	09/29/2014	UR Denial Date:	01/20/2014
Priority:	Standard	Application Received:	02/03/2014

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:

The injured worker is a 57 year-old female who reported an injury on 09/07/2007. The mechanism of injury was not provided. On 12/10/2013, the injured worker presented with pain and stiffness in the bilateral shoulders. Upon examination, there was tenderness to palpation in the bilateral AC joints, rhomboids, and axial insertion of the lateral latissimus dorsal. There were trigger points palpated in the upper trapezius, mid trapezius, lower trapezius and rhomboid regions bilaterally. The range of motion values for the left shoulder was 170 degrees of forward flexion, 30 degrees of extension, and 90 degrees of abduction. The range of motion values for the right shoulder revealed 100 degrees of forward flexion, 30 degrees of extension, and 90 degrees of abduction. There were paresthesias noted to light touch over the 3rd through 5th digits of the right hand. Diagnoses were frozen shoulder, impingement of the shoulder, complete rotator cuff rupture, and rotator cuff syndrome bursitis. Prior therapy included surgery and medications. The provider recommended a magnetic resonance imaging (MRI) of the bilateral shoulders and thoracic spine along with chiropractic and physical therapy treatment. The provider's rationale for the MRIs of the bilateral shoulders was for evaluation of progressive rotator cuff dysfunction or tearing. The Request for Authorization Form was not included in the medical documents for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI OF RIGHT 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 Shoulder Chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-209.

Decision rationale: The request for MRI of the right shoulder is not medically necessary. The California MTUS ACOEM Guidelines state for most injured workers with shoulder problems, special studies are not needed unless a 4 to 6 week period of conservative care and observation fails to improve symptoms. Most injured workers improve quickly provided red flag conditions are ruled out. The criteria for ordering imaging studies include emergence of a red flag, physiologic evidence of a tissue insult or neurovascular 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 documentation provided of conservative treatment the injured worker underwent and the efficacy of the prior treatments. Additionally, there is no documentation to describe a new injury, or red flag findings to suggest that an MRI would be needed. Prior imaging studies were not provided. Additionally, there was no documentation of when the last MRI was previously done. As such, medical necessity has not been established.

MRI OF 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 Shoulder Chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-209.

Decision rationale: The request for MRI of the left shoulder is not medically necessary. The California MTUS ACOEM Guidelines state for most injured workers with shoulder problems, special studies are not needed unless a 4 to 6 week period of conservative care and observation fails to improve symptoms. Most injured workers improve quickly provided red flag conditions are ruled out. Criteria for ordering imaging studies include emergence of a red flag, physiologic evidence of a tissue insult or neurovascular 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 documentation provided of conservative treatment the injured worker underwent and the efficacy of the prior treatments. Additionally, there is no documentation to describe a new injury, or red flag findings to suggest that an MRI would be needed. Prior imaging studies were not provided. Additionally, there was no documentation of when the last MRI was previously done. As such, medical necessity has not been established.

MRI OF THORACIC SPINE: 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), Lumbar.

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

Decision rationale: The request for MRI of the thoracic spine is not medically necessary. The California MTUS ACOEM Guidelines state for most injured workers with thoracic spine problems, special studies are not needed unless a 4 to 6 week period of conservative care and observation fails to improve symptoms. Most injured workers improve quickly provided red flag conditions are ruled out. Criteria for ordering imaging studies include emergence of a red flag, physiologic evidence of a tissue insult or neurovascular 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 documentation provided of conservative treatment the injured worker underwent and the efficacy of the prior treatments. Additionally, there is no documentation to describe a new injury, or red flag findings to suggest that an MRI would be needed. Prior imaging studies were not provided. Additionally, there was no documentation of when the last MRI was previously done. As such, medical necessity has not been established.

CHIROPRACTIC TREATMENT TWO TIMES PER WEEK FOR SIX WEEKS TO BILATERAL SHOULDERS AND BACK: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation Page(s): 58-60.

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

Decision rationale: The request for chiropractic treatment two times per week for six weeks to bilateral shoulders and back is not medically necessary. The California MTUS Guidelines state that chiropractic care for chronic pain, if caused by musculoskeletal conditions, is recommended. The intended goal or effect of manual medicine is the achievement of positive symptomatic or objective measurable gains and functional improvement to facilitate progression in the injured worker's therapeutic exercise program and return to productive activities. The guidelines recommend a trial of 6 visits over 2 weeks, and with evidence of objective functional improvement, a total of up to 18 visits over 6 to 8 weeks. There is lack of documentation indicating the injured worker had significant objective functional improvement with the prior therapy. Additionally, the amount of chiropractic treatment visits the injured worker already underwent was not provided. The provider's request for treatment 2 times a week for 6 weeks exceeds the guideline recommendations. As such, medical necessity has not been established.

PHYSICAL THERAPY TWO TIMES PER WEEK FOR SIX WEEKS TO BILATERAL SHOULDERS AND BACK: Upheld

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

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

Decision rationale: The request for physical therapy two times per week for six weeks to the bilateral shoulders and back is not medically necessary. The California MTUS state that active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, and 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 main improvement levels. There was lack of documentation indicating the injured worker's prior physical therapy, as well as the efficacy of the prior therapy. The guidelines recommend 10 visits of physical therapy for up to 4 weeks. The amount of physical therapy visits that have already been completed was not provided. The provider's request for physical therapy 2 times a week for 6 weeks exceeds the guideline recommendations. Injured workers are instructed and expected to continue active therapies at home, as there are no significant barriers to transitioning the injured worker to an independent home exercise program. As such, medical necessity has not been established.