MAXIMUS Federal Services

Case Number:	CM14-0019178		
Date Assigned:	04/23/2014	Date of Injury:	11/05/2008
Decision Date:	07/07/2014	UR Denial Date:	01/20/2014
Priority:	Standard	Application Received:	02/14/2014

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 Pain Medicine and is licensed to practice in Minnesota. 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 female who reported an injury on 11/05/2008; the mechanism of injury was not provided within the medical records. The clinical note dated 01/17/2014 indicated a diagnosis of impingement syndrome right shoulder with tendinitis. The injured worker reported increased pain to the right shoulder. On physical exam of the right shoulder, there was painful range of motion to forward flexion of 160 degrees, abduction was 140 degrees, internal rotation was 70 degrees and external rotation was 70 degrees. The injured worker's Neer's and Hawkins' tests were positive and the injured worker had general weakness throughout her motion. The injured worker's prior treatments have included physical therapy and medication management. The provider submitted a request for physical therapy 3 times a week for 4 weeks for the neck and bilateral shoulders and MRI of the left shoulder. A Request for Authorization was not submitted for review to include the date the treatment was requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

PHYSICAL THERAPY EVAL AND TREATMENT, 3 TIMES A WEEK FOR 4 WEEKS, FOR THE NECK AND BILATERAL SHOULDERS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines PHYSICAL MEDICINE.

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

Decision rationale: The request for physical therapy evaluation and treatment, 3 times a week for 4 weeks, for the neck and bilateral shoulders is not medically necessary. The Chronic Pain Medical Treatment Guidelines recommend that 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. 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 completed physical therapy should have been adequate to improve functionality and transition the injured worker to a home exercise program where the injured worker may continue with exercises such as strengthening, stretching, and range of motion. In addition, the request for 12 additional weeks of physical therapy would exceed the guideline recommendation. Furthermore, the documentation submitted did not indicate what physical therapy the injured worker completed. Therefore, the request for physical therapy evaluation and treatment, 3 times a week for 4 weeks, for the neck and bilateral shoulders is not medically necessary.

MRI LEFT SHOULDER: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211-214.

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

Decision rationale: The request for MRI left shoulder is not medically necessary. The Chronic Pain Medical Treatment Guidelines state for most patients with shoulder problems, special studies are not needed unless a 4 week to 6 week period of conservative care and observation fails to improve symptoms. Most patients improve quickly, provided red-flag conditions are ruled out. The guidelines also state the primary criteria for ordering an MRI are emergence of a red flag (e.g., indications of intra-abdominal or cardiac problems presenting as shoulder problems), physiologic evidence of tissue insult or neurovascular dysfunction (e.g., cervical root problems presenting as shoulder pain, weakness from a massive rotator cuff tear, or the presence of edema, cyanosis or Raynaud's phenomenon), failure to progress in a strengthening program intended to avoid surgery, and clarification of the anatomy prior to an invasive procedure (e.g., a full thickness rotator cuff tear not responding to conservative treatment). There are no emergent red flag indications. In addition, the documentation submitted did not indicate the injured worker had findings that would support she was at risk for a massive rotator cuff tear or the presence of edema, cyanosis, or Raynaud's phenomenon. Additionally, there was lack of documentation to indicate the injured worker failed to progress in a strengthening program intended to avoid surgery. Furthermore, there is a lack of documentation indicating the injured worker did not respond to conservative treatment. Therefore, the request for MRI left shoulder is not medically necessary.