

Case Number:	CM14-0165941		
Date Assigned:	10/13/2014	Date of Injury:	03/05/2013
Decision Date:	12/31/2014	UR Denial Date:	09/05/2014
Priority:	Standard	Application Received:	10/08/2014

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 Orthopedic Surgery 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:

According to the records made available for review, this is a 58-year-old male with a 3/5/13 date of injury and status post arthroscopic repair of rotator cuff tear and subacromial decompression right shoulder on 4/3/14. At the time (7/22/14) of the request for authorization for Consultation with a Physical Medicine and Rehabilitation for medication, post-operative physical therapy for the right shoulder and cervical spine, MRI (magnetic resonance imaging) of the right wrist, and MRI (magnetic resonance imaging) of the left wrist, there is documentation of subjective (constant moderate dull, achy, sharp neck pain, stiffness and weakness; intermittent severe dull, achy, sharp right shoulder pain; and intermittent right and left wrist pain, tingling and weakness) and objective (cervical spine ranges of motion are decreased and painful, tenderness to palpation of the cervical paravertebral muscles, trigger points of paraspinals lesion present at the lumbar spine, decreased lumbar spine range of motion, tenderness to palpation of the anterior shoulder and posterior shoulder on the right, supraspinatus press is positive, decreased and painful range of motion of the wrists bilaterally, tenderness to palpation of the lateral and volar wrists bilaterally, Phalen's is positive) findings, current diagnoses (cervical disc protrusion, cervical radiculopathy, cervical sprain/strain, right shoulder impingement syndrome, right shoulder sprain/strain, right carpal tunnel syndrome, right wrist pain, right wrist sprain/strain, left carpal tunnel syndrome, left wrist pain, and left wrist sprain/strain), and treatment to date (medication and post-operative physical therapy). Regarding Consultation with a Physical Medicine and Rehabilitation for medication, there is no documentation clarifying how Consultation with a Physical Medicine and Rehabilitation for medication will aid in the diagnosis, prognosis, therapeutic management, determination of medical stability, and permanent residual loss and/or the examinee's fitness for return to work. Regarding post-operative physical therapy for the right shoulder and cervical spine, the number of prior postoperative physical therapy cannot be

determined. In addition, In addition, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of previous physical therapy treatments. Regarding MRI (magnetic resonance imaging) of the right wrist and MRI (magnetic resonance imaging) of the left wrist, there is no documentation of a four-to-six week period of conservative care and observation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Consultation with a Physical Medicine and Rehabilitation for medication: 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), Office Visits

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Independent Medical Examinations and consultations, page(s) 127

Decision rationale: MTUS reference to ACOEM guidelines identifies that consultation is indicated to aid in the diagnosis, prognosis, therapeutic management, determination of medical stability, and permanent residual loss and/or the examinee's fitness for return to work, as criteria necessary to support the medical necessity to support the medical necessity of consultation. Within the medical information available for review, there is documentation of diagnoses of cervical disc protrusion, cervical radiculopathy, cervical sprain/strain, right shoulder impingement syndrome, right shoulder sprain/strain, right carpal tunnel syndrome, right wrist pain, right wrist sprain/strain, left carpal tunnel syndrome, left wrist pain, and left wrist sprain/strain. However, there is no documentation clarifying how Consultation with a Physical Medicine and Rehabilitation for medication will aid in the diagnosis, prognosis, therapeutic management, determination of medical stability, and permanent residual loss and/or the examinee's fitness for return to work. Therefore, based on guidelines and a review of the evidence, the request for Consultation with a Physical Medicine and Rehabilitation for medication is not medically necessary.

Post-operative physical therapy for the right shoulder and cervical spine: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck & Back Procedure Summary

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 27. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Physical Therapy (PT) Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

Decision rationale: MTUS Postsurgical Treatment Guidelines identifies up to 24 visits of post-operative physical therapy over 14 weeks and post-surgical physical medicine treatment period of up to 6 months. In addition, MTUS postsurgical treatment Guidelines identifies that the initial course of physical therapy following surgery is 1/2 the number of sessions recommended for the general course of therapy for the specified surgery. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. ODG identifies that when treatment requests exceeds guideline recommendations, the physician must provide a statement of exceptional factors to justify going outside of guideline parameters. Within the medical information available for review, there is documentation of diagnoses of cervical disc protrusion, cervical radiculopathy, cervical sprain/strain, right shoulder impingement syndrome, right shoulder sprain/strain, right carpal tunnel syndrome, right wrist pain, right wrist sprain/strain, left carpal tunnel syndrome, left wrist pain, and left wrist sprain/strain. In addition, there is documentation of status post arthroscopic repair of rotator cuff tear and subacromial decompression right shoulder on 4/3/14 and previous postoperative physical therapy treatments. However, the number of prior postoperative physical therapy cannot be determined. In addition, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of previous physical therapy treatments. Furthermore, if the number of prior visits, in addition to the requested post-operative physical therapy for the right shoulder and cervical spine exceeds guidelines, there is no documentation of a statement of exceptional factors to justify going outside of guideline parameters. Therefore, based on guidelines and a review of the evidence, the request for post-operative physical therapy for the right shoulder and cervical spine is not medically necessary.

MRI (magnetic resonance imaging) of the right wrist: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 268. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Forearm, wrist & Hand Procedure Summary, MRI

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 268. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm/Wrist/hand Chapter, Magnetic resonance imaging (MRI)

Decision rationale: MTUS reference to ACOEM Guidelines identifies documentation of wrist problems or red flags after four-to-six week period of conservative care and observation, as criteria necessary to support the medical necessity of wrist imaging. ODG identifies documentation of Tumors, benign, malignant, metastatic; Infection or Inflammatory Conditions; Fracture or Trauma Evaluation when adequate diagnostic evaluation is not available on plain films; Neuropathic Osteodystrophy (e.g., Charcot Joint); Other signs, symptoms and conditions (Hemarthrosis documented by arthrocentesis; or Osteonecrosis; or Intra-articular loose body, including synovial osteochondromatosis; or Significant persistent pain unresponsive to a trial of 4 weeks of conservative management; or Abnormalities on other imaging (plain films or bone

scans) requiring additional information to direct treatment decisions); suspicion of carpal instability, triangular cartilage ligament tears particularly when done in association with an arthrogram; scaphoid fracture; or Ulnar collateral ligament tear (Gamekeeper's thumb), as criteria necessary to support the medical necessity of wrist/hand MRI. Within the medical information available for review, there is documentation of diagnoses of cervical disc protrusion, cervical radiculopathy, cervical sprain/strain, right shoulder impingement syndrome, right shoulder sprain/strain, right carpal tunnel syndrome, right wrist pain, right wrist sprain/strain, left carpal tunnel syndrome, left wrist pain, and left wrist sprain/strain. In addition, there is documentation of wrist problems. However, there is no documentation of a four-to-six week period of conservative care and observation. Therefore, based on guidelines and a review of the evidence, the request for MRI (magnetic resonance imaging) of the right wrist is not medically necessary.

MRI (magnetic resonance imaging) of the left wrist: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 268. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Forearm, wrist & Hand Procedure Summary, MRI

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 268. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm/Wrist/hand Chapter, Magnetic resonance imaging (MRI)

Decision rationale: MTUS reference to ACOEM Guidelines identifies documentation of wrist problems or red flags after four-to-six week period of conservative care and observation, as criteria necessary to support the medical necessity of wrist imaging. ODG identifies documentation of Tumors, benign, malignant, metastatic; Infection or Inflammatory Conditions; Fracture or Trauma Evaluation when adequate diagnostic evaluation is not available on plain films; Neuropathic Osteodystrophy (e.g., Charcot Joint); Other signs, symptoms and conditions (Hemarthrosis documented by arthrocentesis; or Osteonecrosis; or Intra-articular loose body, including synovial osteochondromatosis; or Significant persistent pain unresponsive to a trial of 4 weeks of conservative management; or Abnormalities on other imaging (plain films or bone scans) requiring additional information to direct treatment decisions); suspicion of carpal instability, triangular cartilage ligament tears particularly when done in association with an arthrogram; scaphoid fracture; or Ulnar collateral ligament tear (Gamekeeper's thumb), as criteria necessary to support the medical necessity of wrist/hand MRI. Within the medical information available for review, there is documentation of diagnoses of cervical disc protrusion, cervical radiculopathy, cervical sprain/strain, right shoulder impingement syndrome, right shoulder sprain/strain, right carpal tunnel syndrome, right wrist pain, right wrist sprain/strain, left carpal tunnel syndrome, left wrist pain, and left wrist sprain/strain. In addition, there is documentation of wrist problems. However, there is no documentation of a four-to-six week period of conservative care and observation. Therefore, based on guidelines and a review of the evidence, the request for MRI (magnetic resonance imaging) of the left wrist is not medically necessary.