

Case Number:	CM14-0170153		
Date Assigned:	10/20/2014	Date of Injury:	11/04/1998
Decision Date:	11/20/2014	UR Denial Date:	09/24/2014
Priority:	Standard	Application Received:	10/15/2014

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 Interventional Spine 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 patient is a 76-year-old female with date of injury of 11/04/1998. The listed diagnoses per [REDACTED] from 09/17/2014 are: 1. Lumbar radiculopathy. 2. S/P left knee arthroscopy. According to this handwritten progress report, the patient has not received any treatment since her last visit. She did not receive the corset and physical therapy was denied per the UR determination of 08/27/2014. The patient occasionally takes Tylenol for pain. The examination from the 08/19/2014 report shows left arm with a large region of ecchymosis, otherwise, symptoms persist with regards to the back and lower extremities. Left shoulder with a positive impingement sign and decreased range of motion. The utilization review denied the request on 09/24/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy to the left shoulder QTY: 8: Overturned

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): 98-99.

Decision rationale: This patient presents with back and left upper extremity pain. The treater is requesting 8 physical therapy sessions for the left shoulder. The MTUS Guidelines page 98 and 99 on physical medicine recommends 8 to 10 visits for myalgia, myositis, and neuralgia type symptoms. The utilization review denied the request stating, "The PTP has not documented in the current report any subjective or objective findings that support the request for physical therapy." The 05/06/2014 report notes that the patient is scheduled to see [REDACTED] for QME on 08/06/2014. Symptoms persist regarding the back and extremities including periodic radicular symptoms and shoulder pain. The 07/09/2014 report notes that the patient recently had a fall about a week ago when her cane tangled up in her ankle and injured her right thigh. She was in the hospital for 2 days. The 08/19/2014 report notes increased reports of left shoulder pain and the left arm with a large region of ecchymosis; otherwise, symptoms persist in the back and lower extremities. Left shoulder with a positive impingement and decreased range of motion. The records do not show any physical therapy reports to verify how many treatments the patient has received and with what results. It appears that the patient has not had any recent physical therapy treatments for the left shoulder. Given documentation of persistent pain in the left shoulder, a short course of treatment is reasonable and the requested 8 sessions are within MTUS Guidelines therefore request is medically necessary.

MRI of the left shoulder QTY: 1: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG (Official Disability Guidelines) Online: MRI (magnetic resonance imaging); MR arthrogram

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-208. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) under the Shoulder chapter on MRI

Decision rationale: This patient presents with back and left upper extremity pain. The treater is requesting an MRI of the left shoulder. The ACOEM Guidelines page 207 to 208 the primary criteria for ordering imaging studies include: Emergence of red flag; physiologic evidence of tissue insult; failure to progress in strengthening program; and clarification of anatomy prior to an invasive procedure. ODG further states that magnetic resonance imaging and arthrography has fairly similar diagnostic and therapeutic impact and comparable accuracy, although MRI is more sensitive and less specific. The records do not show any previous MRI of the left shoulder. The 08/19/2014 report notes that the patient has increased left shoulder pain for which an injection was requested. The left arm has a large region of ecchymosis; otherwise, symptoms persist regarding the back and lower extremities. The left shoulder has a positive impingement sign with decreased range of motion. The treater injected a 0.5 mL corticosteroid and 1.5 mL lidocaine into the left subacromial space under sterile conditions with reports of relief. In this case, given the patient's recent fall and persistent symptoms in the left shoulder, an MRI is reasonable therefore request is medically necessary.