

<b>Case Number:</b>	CM14-0046229		
<b>Date Assigned:</b>	07/02/2014	<b>Date of Injury:</b>	01/23/2004
<b>Decision Date:</b>	09/18/2014	<b>UR Denial Date:</b>	03/21/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/14/2014

### 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 Occupational Medicine 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 66-year-old female who has submitted a claim for complete rotator cuff tear left shoulder, osteoarthritis left hand, and polio with flailed withered right upper extremity associated with an industrial injury date of 01/23/2004. Medical records from 09/18/2012 to 07/02/2014 were reviewed and showed that patient complained of left shoulder pain (grade not specified). Physical examination of the left shoulder revealed left shoulder weakness and restricted ROM. Physical examination of the right shoulder revealed flailed right arm secondary to polio. Of note, fluoroscan x-ray of bilateral shoulders was done on 12/09/2013 as patient was noted to have significant pain in the left shoulder with physical findings of decreased left shoulder ROM, weakness of the supraspinatus and infraspinatus and positive arc and impingement tests. Fluoroscan x-ray of the right shoulder dated 12/09/2013 showed previous glenohumeral joint arthrodesis. Fluoroscan x-ray of the left shoulder dated 12/09/2013 showed moderate acromioclavicular joint degenerative changes and mild to moderate glenohumeral joint degenerative changes. MRI of the left shoulder dated 06/23/2009 revealed full thickness rotator cuff tear, absence of longhead of biceps tendon and moderate degenerative changes of acromioclavicular joint. Treatment to date has included left shoulder rotator cuff repair (09/14/2009), 10 postoperative physical therapy visits, corticosteroid injection, and pain medications.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Magnetic resonance imaging of the right shoulder with gadolinium.:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 208-209. Decision based on Non-MTUS Citation Official Disability Guidelines: Shoulder (acute & Chronic).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 208-209. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, MRI.

**Decision rationale:** According to pages 208 and 209 of the ACOEM Practice Guidelines, 2nd Edition (2004) referenced by CA MTUS , the criteria for MRI include emergence of a red flag; physiologic evidence of tissue insult or neurologic dysfunction; failure to progress in a strengthening program intended to avoid surgery; or clarification of the anatomy prior to an invasive procedure. In addition, Official Disability Guidelines states that the criteria for shoulder MRI include normal plain radiographs, shoulder pain, and suspected pathology likely to be demonstrated on MRI. In this case, the physical examination findings revealed limited left shoulder ROM and left shoulder weakness. There was no documentation of failure to progress in a strengthening program. There was no clear indication for MRI study based on the available records. The subjective and objective complaints did not show emergence of a red flag sign to support the study. Therefore, the request for Magnetic resonance imaging of the right shoulder with gadolinium is not medically necessary.

**Twelve physical therapy sessions.:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines: Physical Therapy.

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

**Decision rationale:** According to pages 98-99 of the CA MTUS Chronic Pain Medical Treatment Guidelines, active therapy is recommended for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Physical medicine guidelines allow for fading of treatment frequency from up to 3 visits per week to 1 or less plus active self-directed home physical medicine. In this case, the patient has already completed 10 visits of physical therapy. It is unclear as to why the patient cannot self-transition into HEP. Therefore, the request for twelve physical therapy sessions is not medically necessary.

**One fluro scan x-ray of the bilateral shoulders.:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207, 214. Decision based on Non-MTUS Citation Official Disability Guidelines: shoulder (acute & Chronic).

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

**Decision rationale:** The MTUS ACOEM guidelines state that diagnostic studies are needed when there is a new injury, red flags or a trauma. In this case, recent subjective and objective findings of bilateral shoulders do indicate a new injury, trauma, or red flags to necessitate fluoroscan x-ray of bilateral shoulders. Of note, patient was noted to have significant pain in the left shoulder with physical findings of decreased left shoulder ROM, weakness of the supraspinatus and infraspinatus and positive arc and impingement tests (12/09/2013). The medical necessity for retrospective left shoulder x-ray has been established. However, there was no documentation of subjective or objective findings of the right shoulder to support x-ray imaging. There was no clear indication for retrospective fluoroscan x-ray of the right shoulder based on the reviewed medical record (12/09/2013). Therefore, the request for one fluoro scan x-ray of the bilateral shoulders is not medically necessary.