

<b>Case Number:</b>	CM14-0073572		
<b>Date Assigned:</b>	08/06/2014	<b>Date of Injury:</b>	11/29/2011
<b>Decision Date:</b>	09/10/2014	<b>UR Denial Date:</b>	05/06/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/20/2014

### 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 Management 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:

This is a female injured worker has a date of injury of November 29, 2011. A utilization review was performed on May 6, 2014 and recommended partial certification of chiropractic therapy and physical therapy and non-certification of MRI of cervical spine and left shoulder MR arthrogram. There is note of prior chiropractic therapy and physical therapy. A progress report dated April 25, 2014 identifies subjective complaints of neck pain 7/10, left shoulder 6/10, and right shoulder 8/10. Objective findings identify ROM restricted with pain, palpable tenderness at cervical spine and bilateral shoulders, and positive Ortho test for dysfunction. Diagnoses identify HNP cervical spine, bilateral shoulder derangement, and radiculopathy. Treatment Plan identifies request bilateral shoulder arthrogram, MRI cervical spine, 6 visits chiropractic, and 8 visits of physical therapy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Chiropractic therapy , 6 sessions:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation Page(s): 58-59.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58-60.

**Decision rationale:** The guidelines support the use of chiropractic care for the treatment of chronic pain caused by musculoskeletal conditions. Guidelines go on to recommend a trial of up to 6 visits over 2 weeks for the treatment of low back pain. With evidence of objective functional improvement, a total of up to 18 visits over 6 to 8 weeks may be supported. Within the documentation available for review, it is unclear exactly what objective functional deficits are intended to be addressed with the currently requested chiropractic care. Additionally, there is no evidence of objective functional improvement with previous therapy. In the absence of clarity regarding the above issues, the request for chiropractic therapy, 6 visits is not medically necessary.

**MRI of cervical spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Neck and Upper Back Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 8), pages 176-177.

**Decision rationale:** Regarding the request for MRI of cervical spine, guidelines support the use of imaging for emergence of a red flag, physiologic evidence of tissue insult or neurologic deficit, failure to progress in a strengthening program intended to avoid surgery, and for clarification of the anatomy prior to an invasive procedure. Guidelines also recommend MRI after 3 months of conservative treatment. Within the documentation available for review, there is no indication of any red flag diagnoses. Additionally there is no documentation of neurologic deficit or failure of conservative treatment for at least 3 months. In the absence of such documentation the requested MRI of cervical spine is not medically necessary.

**Physical therapy, 8 sessions:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 98.

**Decision rationale:** The guidelines recommend a short course of active therapy with continuation of active therapies at home as an extension of the treatment process in order to maintain improvement levels. The ODG has more specific criteria for the ongoing use of physical therapy. The ODG recommends a trial of physical therapy. If the trial of physical therapy results in objective functional improvement, as well as ongoing objective treatment goals, then additional therapy may be considered. The ODG recommends up to 12 physical therapy sessions. Within the documentation available for review, there is no indication of any objective functional improvement from the therapy already provided, no documentation of specific ongoing objective treatment goals, and no statement indicating why an independent program of home exercise would be insufficient to address any remaining objective deficits. In

the absence of such documentation, the current request for physical therapy, 8 sessions is not medically necessary.

**Left shoulder MR arthrogram:** 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), Shoulder (Acute & Chronic), Arthrography.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207- 209. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, MR arthrogram.

**Decision rationale:** The guidelines state that more specialized imaging studies are not recommended during the 1st month to 6 weeks of activity limitation due to shoulder symptoms except when a red flag is noted on history or examination. Cases of impingement syndrome are managed the same whether or not radiographs show calcium in the rotator cuff or degenerative changes are seen in or around the glenohumeral joint or AC joint. Guidelines go on to recommend imaging studies for physiologic evidence of tissue insult or neurovascular dysfunction, failure to progress in a strengthening program intended to avoid surgery, and clarification of the anatomy prior to an invasive procedure. The ODG recommends MR arthrogram as an option to detect labral tears, and for suspected re-tear post-op rotator cuff repair. Within the documentation available for review, there is no indication of a suspected labral tear or of a re-tear post-op rotator cuff repair. In the absence of such documentation, the currently requested left shoulder MR arthrogram is not medically necessary.