

<b>Case Number:</b>	CM14-0094329		
<b>Date Assigned:</b>	07/25/2014	<b>Date of Injury:</b>	04/15/2012
<b>Decision Date:</b>	08/29/2014	<b>UR Denial Date:</b>	06/04/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/20/2014

### 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 Orthopaedic 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:

This 46-year-old female certified nursing assistant sustained an industrial injury on 4/15/12. Injury occurred while repositioning a patient in bed. The patient underwent right rotator cuff repair on 9/10/12 with no relief. A second shoulder surgery was performed on 9/10/13. Records indicated that the patient had attended 36 visits of physical therapy, but the time frame was not specified. The 5/14/14 treating physician report cited continued grade 5-6/10 right shoulder pain and swelling, intermittent headaches, and intermittent grade 5/10 low back pain. Right shoulder range of motion was better with therapy. Physical exam documented right-sided cervical spasms and swelling. There was decreased right upper extremity motor and sensation. Deep tendon reflexes were equal. Cervical range of motion was moderately limited in all planes. The diagnosis was right shoulder internal derangement, failed right shoulder surgery, cervicgia, headaches, and lumbar sprain/strain. The treatment plan recommended additional physical therapy for functional improvement to the right shoulder and cervical spine 2x4, MRI cervical spine, upper extremity EMG/NCV (Electromyography / Nerve Conduction Velocity), and continued medications (Relafen, Prilosec, Flexeril, and Ultram). The patient was capable of modified work. The 6/4/14 utilization review denied the request for additional physical therapy as not medically necessary. The cervical spine MRI was denied as there was no evidence of tissue insult or nerve impairment. A request for bilateral upper extremity EMG/NCV (Electromyography / Nerve Conduction Velocity) was approved. The 6/6/14 upper extremity electrodiagnostic study revealed bilateral mild carpal tunnel syndrome.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Additional eight (8) Physical Therapy sessions for Right Shoulder: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chronic Pain Treatment Guidelines Physical Medicine Page(s): 99. Decision based on Non-MTUS Citation Official Disability Guidelines Shoulder, Neck and Upper Back.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Introduction and Physical Medicine Page(s): 9,98-99.

**Decision rationale:** California MTUS Post-Surgical Treatment Guidelines do not apply to this case as the 6-month post-surgical treatment period had expired. MTUS Chronic Pain Medical Treatment Guidelines would apply. The MTUS guidelines recommend therapies focused on the goal of functional restoration rather than merely the elimination of pain. The physical therapy guidelines state that patients are expected to continue active therapies at home as an extension of treatment and to maintain improvement. Guideline criteria have not been met. There is no indication as to how much physical therapy has been provided to either the right shoulder or cervical region and what, if any, objective measurable functional benefit was achieved. There is no current functional assessment or specific functional treatment goals documented to be addressed by additional physical therapy. There is no compelling reason to support the medical necessity of additional supervised physical therapy over an independent home exercise program at this time. Therefore, this request for Additional eight (8) Physical Therapy sessions for Right Shoulder is not medically necessary and appropriate.

**MRI for Cervical Spine: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines Neck & Upper Back Electromyography.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178.

**Decision rationale:** The California MTUS guidelines provide criteria for ordering cervical spine MRIs that includes emergence of a red flag, physiologic evidence of tissue insult or neurologic dysfunction, failure in a strengthening program intended to avoid surgery, or clarification of anatomy prior to an invasive procedure. Reliance only on imaging studies to evaluate the source of neck or upper back symptoms carries a significant risk of diagnostic confusion (false-positive test results) because it's possible to identify a finding that was present before symptoms began and, therefore, has no temporal association with the symptoms. Guideline criteria have not been met. There is no specific physiologic evidence of tissue insult or neurologic dysfunction. Exam findings documented non-specific decreased motor and sensation with no myotomal or dermatomal pattern. Electrodiagnostic studies were negative for cervical radiculopathy, but evidenced mild bilateral carpal tunnel syndrome. Therefore, this request for a cervical spine MRI is not medically necessary.

