

Case Number:	CM14-0191339		
Date Assigned:	11/25/2014	Date of Injury:	11/23/2010
Decision Date:	01/12/2015	UR Denial Date:	10/22/2014
Priority:	Standard	Application Received:	11/17/2014

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:

The patient is a 54 year old male with an injury date of 11/23/10. Based on the 04/24/14 progress report, the patient complains of neck pain which goes down to his shoulders and low back pain which radiates down to his left leg down to the ankle. He has positive impingement signs with Hawkins and Neer testing of bilateral shoulders. The 07/11/14 report indicates that the patient also has right arm pain. The 10/06/14 report states that the patient has cervical spine pain which radiates to his bilateral upper extremities. He has constant dull pain to his left shoulder as well as pain in his right hand/wrist. The foraminal compression test produces local pain and the patient has spasms present at the base of the paracervicals. The patient's diagnoses include the following: Cervical strain Lumbar strain with disc protrusion L5-S1 Left shoulder impingement syndrome The utilization review determination being challenged is dated 10/22/14. Treatment reports were provided from 03/11/14- 10/06/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Aspen quick draw brace: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, lumbar supports

Decision rationale: The patient presents with cervical spine pain which radiates to his bilateral upper extremities, left shoulder pain, right hand/wrist pain, and low back pain which radiates down to his left leg down to the ankle. The request is for an aspen quick draw brace.ACOEM Guidelines page 301 on lumbar bracing state, "Lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief." ODG Guidelines under its Low Back Chapter, lumbar supports states, "Prevention: Not recommended for prevention. There is strong and consistent evidence that lumbar supports were not effective in preventing neck and back pain." Under treatment ODG further states, "Recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, and for treatment of nonspecific LBP (very low-quality evidence, but may be a conservative option)." In this case, the patient does not present with fracture, documented instability, or spondylolisthesis to warrant lumbar bracing. For non-specific low back pain, there is very low quality evidence. The requested aspen quick draw brace is not medically necessary.

MR Arthrogram of left shoulder: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder (Acute & Chronic) MR Arthrogram

Decision rationale: The patient presents with cervical spine pain which radiates to his bilateral upper extremities, left shoulder pain, right hand/wrist pain, and low back pain which radiates down to his left leg down to the ankle. The request is for an MR ARTHROGRAM OF LEFT SHOULDER. Review of the reports does not indicate if the patient had a prior MR Arthrogram of the left shoulder.The MTUS guidelines do not address MRI's but ODG guidelines states for MR Arthrogram of shoulder, "Recommended as an option to detect labral tears, and for suspected re-tear post-op rotator cuff repair. MRI is not as good for labral tears, and it may be necessary in individuals with persistent symptoms and findings of a labral tear that a MR Arthrogram be performed even with negative MRI of the shoulder, since even with a normal MRI, a labral tear may be present in a small percentage of patients." Review of reports does not indicate that the patient had shoulder surgery to "suspected re-tear post-op rotator cuff repair" or to detect a labral tear. The provider does not mention why an MR Arthrogram is needed. The requested MR Arthrogram of the left shoulder is not medically necessary.

Physical therapy 3 times a week for 4 weeks: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: The patient presents with cervical spine pain which radiates to his bilateral upper extremities, left shoulder pain, right hand/wrist pain, and low back pain which radiates down to his left leg down to the ankle. The request is for physical therapy 3 times a week for 4 weeks for the cervical and lumbar spine to decrease pain and increase range of motion. The 04/24/14 report states that the patient has "done physical therapy before, which did help mildly." There is no indication of how many total sessions of physical therapy the patient may have had. MTUS pages 98, 99 have the following: "Physical Medicine: recommended as indicated below. Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine." MTUS guidelines page 98 and 99 states that for "Myalgia and myositis, 9-10 visits are recommended over 8 weeks. For Neuralgia, neuritis, and radiculitis, 8-10 visits are recommended." In this case, the patient has had physical therapy before. However it is unknown how many sessions of therapy the patient has had in total. The provider has requested for a total of 12 sessions of physical therapy which exceeds what is allowed by MTUS. The requested physical therapy 3 times a week for 4 weeks is not medically necessary.