

Case Number:	CM14-0194273		
Date Assigned:	12/02/2014	Date of Injury:	11/22/2010
Decision Date:	03/05/2015	UR Denial Date:	11/12/2014
Priority:	Standard	Application Received:	11/20/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: Maryland

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Neuromuscular Medicine

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 59 year old male who has a work injury dated 11/22/10. The diagnoses include disc bulge cervical spine; disc bulge lumbar spine; rotator cuff right shoulder with labral tear; rotator cuff injury left shoulder with labral tear status post left shoulder subacromial decompression distal clavicle surgery 2/19/13 and 24 post op visits with continued pain. Under consideration are requests for MRI of the lumbar spine; Physical Therapy 3 times a week for 4 weeks with ultrasound, massage & therapeutic exercises for right shoulder; physical therapy 3 times a week for 4 weeks with ultrasound, massage & therapeutic exercises for left shoulder; physical therapy 3 times a week for 4 weeks with ultrasound, massage & therapeutic exercises for cervical; physical therapy 3 times a week for 4 weeks with ultrasound, massage & therapeutic exercises for lumbar spine. Per prior utilization review dated 8/5/14 the patient has had 24 post op visits to date and over 100 total combined body part visits of therapy with persistent symptoms. An 11/17/14 MRI of the left shoulder reveals mild tenosynovitis of the long head of the biceps tendon. There is tendinosis and peritendinitis of the supraspinatus tendon with no rotator cuff tears. There are osteoarthritic changes of the acromioclavicular joint and glenohumeral joint. There is no fracture or dislocations. There is a 7/22/14 progress note that states that the patient is here for an evaluation of a painful condition around the neck and shoulders. He continues to have pain and stiffness in his neck and low back. He has pain down his right lower extremity. He has pain which is increased to the left shoulder. On exam his cervical spine had no deformity. There is spasm around the trapezial area. There is point tenderness on palpation about the paraspinals. The pain is reproduced with motion. The patient

has full cervical flexion, extension and decreased right and left lateral bending and rotation. The right shoulder has uncomfortable pain and generalized weakness with motion. The left shoulder has a positive O'Brien's test and uncomfortable pain and generalized weakness with motion. There is decreased left shoulder range of motion in all planes. The lumbar spine has spasm and point tenderness. There is decreased lumbar spine range of motion. There is 5/5 bilateral upper strength in the C5-T1 myotomes and full 5/5 strength in the bilateral L2-S1 myotomes. The sensation is normal in all dermatomes of the bilateral upper and lower extremities. The reflexes are intact in the bilateral upper and lower extremities. The treatment plan includes physical therapy 3 x week for 4 weeks. The disability status is temporary total disability. An 11/18/14 appeal states that an appeal is requested for the patient's physical therapy due to his persistent pain and spasm in his neck and back and radiating RLE numbness. He has difficulty with his activities of daily living. The patient has not had an MRI in 3 years and his symptoms have become significantly worse. The document states that he has significant weakness, loss of range of motion and difficulties with his ADLs.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303,304. Decision based on Non-MTUS Citation Low Back

Decision rationale: MRI of the lumbar spine is not medically necessary per the MTUS and the ODG Guidelines. The MTUS recommends imaging studies be reserved for cases in which surgery is considered, or there is a red-flag diagnosis. The guidelines state that unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment. The ODG recommends a lumbar MRI when there is a suspected red flag condition such as cancer or infection or when there is a progressive neurologic deficit. Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (eg, tumor, infection, fracture, neurocompression, recurrent disc herniation). The documentation submitted does not reveal progressive neurologic deficits, or a red flag diagnoses. There is no documentation how an MRI would alter this treatment plan. The request for MRI of the lumbar spine is not medically necessary.

Physical Therapy 3 times a week for 4 weeks with ultrasound, massage & therapeutic exercises for Right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chronic Pain Treatment Guidelines Physical Medicine and Massage Therapy.

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

Decision rationale: Physical Therapy 3 times a week for 4 weeks with ultrasound, massage & therapeutic exercises for Right shoulder is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The documentation indicates that the patient has had 24 post op visits to date and over 100 total combined body part visits of therapy with persistent symptoms. The documentation is not clear on the precise therapy for each body part, the efficacy of the prior therapy in terms of objective documentation of functional improvement. There are no objective physical therapy documents submitted for review. The MTUS recommends up to 10 visits for this condition with a fading of frequency towards an active self directed home program. There are no extenuating circumstances requiring 12 sessions of additional therapy which exceed guideline recommendations. The request for physical therapy 3 times a week for 4 weeks with ultrasound, massage and therapeutic exercises is not medically necessary.

Physical Therapy 3 times a week for 4 weeks with ultrasound, massage & therapeutic exercises for left shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chronic Pain Treatment Guidelines Physical Medicine and Massage Therapy.

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

Decision rationale: Physical Therapy 3 times a week for 4 weeks with ultrasound, massage & therapeutic exercises for left shoulder is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The documentation indicates that the patient has had 24 post op visits to date and over 100 total combined body part visits of therapy with persistent symptoms. The documentation is not clear on the precise therapy for each body part, the efficacy of the prior therapy in terms of objective documentation of functional improvement. There are no objective physical therapy documents submitted for review. The MTUS recommends up to 10 visits for this condition with a fading of frequency towards an active self directed home program. There are no extenuating circumstances requiring 12 sessions of additional therapy which exceed guideline recommendations. The request for physical therapy 3 times a week for 4 weeks with ultrasound, massage and therapeutic exercises is not medically necessary.

Physical Therapy 3 times a week for 4 weeks with ultrasound, massage & therapeutic exercises for cervical: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Guidelines.

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

Decision rationale: Physical Therapy 3 times a week for 4 weeks with ultrasound, massage & therapeutic exercises for cervical is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The documentation indicates that the patient has had 24 post op visits to date and over 100 total combined body part visits of therapy with persistent symptoms. The documentation is not clear on the precise therapy for each body part, the efficacy of the prior therapy in terms of objective documentation of functional improvement. There are no objective physical therapy documents submitted for review. The MTUS recommends up to 10 visits for this condition with a fading of frequency towards an active self directed home program. There are no extenuating circumstances requiring 12 sessions of additional therapy which exceed guideline recommendations. The request for physical therapy 3 times a week for 4 weeks with ultrasound, massage and therapeutic exercises is not medically necessary.

Physical Therapy 3 times a week for 4 weeks with ultrasound, massage & therapeutic exercises for lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines Physical Medicine and Massage Therapy.

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

Decision rationale: Physical Therapy 3 times a week for 4 weeks with ultrasound, massage & therapeutic exercises for lumbar spine is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The documentation indicates that the patient has had 24 post op visits to date and over 100 total combined body part visits of therapy with persistent symptoms. The documentation is not clear on the precise therapy for each body part, the efficacy of the prior therapy in terms of objective documentation of functional improvement. There are no objective physical therapy documents submitted for review. The MTUS recommends up to 10 visits for this condition with a fading of frequency towards an active self directed home program. There are no extenuating circumstances requiring 12 sessions of additional therapy which exceed guideline recommendations. The request for physical therapy 3 times a week for 4 weeks with ultrasound, massage and therapeutic exercises is not medically necessary.