

Case Number:	CM14-0202456		
Date Assigned:	12/15/2014	Date of Injury:	08/27/2012
Decision Date:	01/30/2015	UR Denial Date:	11/21/2014
Priority:	Standard	Application Received:	12/03/2014

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:

This case is a 36 year old female a date of injury on August 27, 2012. A review of the medical records indicate that the patient is undergoing treatment for right shoulder impingement syndrome, right bicipital tendinitis, right subacromial subdeltoid bursitis, and lumbar strain/sprain. Current documentation dated October 28, 2014 notes that the injured worker reported right shoulder, arm and hand pain. The pain was described as constant and rated as a six out of ten on the Visual Analogue Scale. Physical examination of the right shoulder revealed fifty percent of full range of motion. The injured worker was noted to have symptoms of adhesive capsulitis. A Neer's, Apley's, Hawkins's and a ninety degree crossover impingement test were positive. Examination of the right hand revealed full range of motion, but pain in the wrist and hand. Examination of the lumbar spine showed decreased flexion and extension and positive paraspinal tenderness to percussion. Diagnostic testing has included an x-ray of the right shoulder dated July 22, 2014 which revealed moderately downsloping orientation of the right acromion which may increase the risk for subacromial impingement syndrome. An MRI of the right shoulder done July 22, 2014 revealed an intact rotator cuff, mild bone marrow edema in the distal end of the right clavicle, which was new from a prior MRI and moderately downsloping orientation of the right acromion which may increase the risk for subacromial impingement syndrome. Medications include Naproxen, Omeprazole and Tramadol. Utilization Review dated 11/21/2014 noncertified the request for:- HEK right shoulder- X-ray of the lumbar spine- Physical therapy 2x6 for the right shoulder- MRI of the lumbar spine

IMR ISSUES, DECISIONS AND RATIONALES

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

HEK right shoulder: 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 based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Home Exercise Kit

Decision rationale: California MTUS does not specifically refer to home exercise kits, but does state "Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices." Official Disability Guidelines (ODG) states regarding Home Exercise Kits, "Recommended. See Exercises, where home exercise programs are recommended; & Physical therapy, where active self-directed home physical therapy is recommended." The treating physician's requested home exercise kit is non-specific. The physician does not detail what components are in the kit and how the exercise equipment is to be utilized in the context of home therapy. The treating physician does note shoulder deficits, but does not specify the medical necessity of the components within the exercise kits. There is no clear and specific medical indication for the 'kit' as it is written. As such, the request for HEK right shoulder is not medically necessary.

X-ray of the 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): 287-315. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Radiography (x-rays)

Decision rationale: American College of Occupational and Environmental Medicine (ACOEM) and Official Disability Guidelines (ODG) both agree that "Lumbar spine x rays should not be recommended in patients with low back pain in the absence of red flags for serious spinal pathology, even if the pain has persisted for at least six weeks." The medical notes provided did not document (physical exam, objective testing, or subjective complaints) any red flags for serious spinal pathology or other findings suggestive of the pathologies outlined in the ODG guidelines. ODG additionally states that "it may be appropriate when the physician believes it would aid in patient management". The treating physician also does not indicate how the x-ray would "aid in patient management". ODG further specifies other indications for imaging with Plain X-rays: Thoracic spine trauma: severe trauma, pain, no neurological deficit Thoracic spine trauma: with neurological deficit Lumbar spine trauma (a serious bodily injury): pain, tenderness Lumbar spine trauma: trauma, neurological deficit Lumbar spine trauma: seat belt (chance) fracture Uncomplicated low back pain, trauma, steroids, osteoporosis, over

70Uncomplicated low back pain, suspicion of cancer, infectionMyelopathy (neurological deficit related to the spinal cord), traumaticMyelopathy, painfulMyelopathy, sudden onsetMyelopathy, infectious disease patientMyelopathy, oncology patientPost-surgery: evaluate status of fusionThe treating physician does not indicate any concerns for the above ODG pathologies. As such, the request for X-ray of the lumbar spine is not medically necessary.

Physical therapy 2x6 for the right shoulder: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy, Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder (Acute & Chronic), Physical Therapy, ODG Preface - Physical Therapy

Decision rationale: California MTUS guidelines refer to physical medicine guidelines for physical therapy. "Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine." Regarding physical therapy, Official Disability Guidelines (ODG) states "Patients should be formally assessed after a "six-visit clinical trial" to see if the patient is moving in a positive direction, no direction, or a negative direction (prior to continuing with the physical therapy); & (6) When treatment duration and/or number of visits exceeds the guideline, exceptional factors should be noted." At the conclusion of this trial, additional treatment would be assessed based upon documented objective, functional improvement, and appropriate goals for the additional treatment. The request for 12 sessions is in excess of the initial trials per MTUS and ODG guidelines. The treating physician does not detail any extenuating circumstances for exceeding guideline recommendations of an initial trial. A trail of physical therapy should occur first and the results of the trial used to tailor ongoing treatment. As such, the request for Physical therapy two times six for the right shoulder is not medically necessary.

MRI of the 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): 287-315. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), MRIs (magnetic resonance imaging)

Decision rationale: California MTUS and American College of Occupational and Environmental Medicine (ACOEM) recommend MRI, in general, for low back pain when "cuada equine, tumor, infection, or fracture are strongly suspected and plain film radiographs are negative, magnetic resonance imaging (MRI) test of choice for patients with prior back surgery" ACOEM additionally recommends against MRI for low back pain "before 1 month in absence of red flags." Official Disability Guidelines (ODG) states, "Imaging is indicated only if they have

severe progressive neurologic impairments or signs or symptoms indicating a serious or specific underlying condition, or if they are candidates for invasive interventions. Immediate imaging is recommended for patients with major risk factors for cancer, spinal infection, cauda equina syndrome, or severe or progressive neurologic deficits. Imaging after a trial of treatment is recommended for patients who have minor risk factors for cancer, inflammatory back disease, vertebral compression fracture, radiculopathy, or symptomatic spinal stenosis. Subsequent imaging should be based on new symptoms or changes in current symptoms." The medical notes provided did not document (physical exam, objective testing, or subjective complaints) any red flags, significant worsening in symptoms or other findings suggestive of the pathologies outlined in the above guidelines. As such, the request for MRI lumbar spine is not medically necessary.