

<b>Case Number:</b>	CM14-0205753		
<b>Date Assigned:</b>	12/17/2014	<b>Date of Injury:</b>	08/02/2014
<b>Decision Date:</b>	03/11/2015	<b>UR Denial Date:</b>	11/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/09/2014

### 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: California, District of Columbia, Maryland  
 Certification(s)/Specialty: Anesthesiology, Pain Management

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

35y/o male injured worker with date of injury 11/7/14 with related left shoulder and low back pain. Per therapy assessment dated 10/7/14, limitation of the left shoulder was noted with intermittent pain. Signs and symptoms felt to be consistent with a superior labrum anterior posterior (SLAP) lesion were noted. Low back pain was improved but there was still some soreness involving the neck and low back. Per progress note dated 10/17/14, the injured worker rated cervical spine pain 4/10, low back pain 2/10, and shoulder pain 2/10. Per physical exam, left shoulder motion did not elicit pain. Strength was intact in all groups about the shoulder. Cervical spine exam demonstrated tenderness over the left trapezius. Lumbar spine exam demonstrated a degree of tenderness in the mid lumbar spine. Straight leg raising was negative. Work status was regular as of 10/17/14. Treatment to date has included physical therapy and medication management. The date of UR decision 11/7/14.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical Therapy Lumbar:** 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:** Per MTUS CPMTG, physical medicine guidelines state: Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. "Per the ODG guidelines, Lumbar sprains and strains (ICD9 847.2):10 visits over 8 weeks Sprains and strains of unspecified parts of back (ICD9 847):10 visits over 5 weeks The documentation submitted for review indicates that the injured worker has already undergone 8 sessions of physical therapy. While it was noted that there were improvements, the latest progress report indicates little in the way of objective pathology present other than tenderness around the paraspinal muscles. Low back pain was rated 2/10, and the injured worker is back to regular work activities, though it is not indicated whether he has returned to work. Furthermore, the request does not specify the quantity of additional sessions requested. Medical necessity cannot be affirmed.

**MR Arthrogram 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, MR arthrogram.

**Decision rationale:** With regard to arthrography, ACOEM states "When surgery is being considered for a specific anatomic defect (e.g., a full-thickness rotator cuff tear). Magnetic resonance imaging and arthrography have fairly similar diagnostic and therapeutic impact and comparable accuracy although MRI is more sensitive and less specific. Magnetic resonance imaging may be the preferred investigation because it demonstrates soft tissue anatomy better." Per the ODG guidelines: Recommended as an option to detect labral tears, and for suspected re-tear post-op rotator cuff repair. Per physical therapy note dated 10/7/14, it was noted that the injured worker presented with signs and symptoms consistent with SLAP tear and that he may benefit from arthrogram. However, specific signs and symptoms were not documented. Per progress report dated 10/17/14, no dysfunction was noted with regard to the shoulder. The documentation contains no clinical findings that support imaging study. The request is not medically necessary.

**Physical Therapy- Cervical, Left 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, Physical Therapy

**Decision rationale:** Per MTUS CPMTG, physical medicine guidelines state: Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine."Per the ODG guidelines: Sprained shoulder; rotator cuff (ICD9 840; 840.4):Medical treatment: 10 visits over 8 weeksMedical treatment, partial tear: 20 visits over 10 weeksPost-surgical treatment (RC repair/acromioplasty): 24 visits over 14 weeksThe documentation submitted for review indicates that the injured worker has already undergone 8 sessions of physical therapy. Per the latest progress report, neck pain was rated 4/10, and shoulder pain was rated 2/10. The injured worker was back to regular work activities, though it was not indicated whether he had returned to work. There were no objective findings present that would support any additional therapy given that the shoulder demonstrated full range of motion and function. Furthermore, the request does not specify the quantity of additional sessions requested. Medical necessity cannot be affirmed.