

<b>Case Number:</b>	CM15-0102908		
<b>Date Assigned:</b>	06/05/2015	<b>Date of Injury:</b>	12/04/2013
<b>Decision Date:</b>	07/24/2015	<b>UR Denial Date:</b>	05/11/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/28/2015

### 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: New York  
 Certification(s)/Specialty: Emergency 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 injured worker is a 55 year old female who has reported the gradual onset of widespread pain attributed to usual work activity, with a listed injury date of December 4, 2013. The diagnoses have included lumbosacral sprain and bilateral upper extremity overuse syndrome. A shoulder MRI on 3/10/15 showed a partial rotator cuff tear and joint fluid. A cervical MRI on 3/10/15 showed multilevel spondylosis. Treatment to date has included medications. The PR2s in 2014-2015 reflect ongoing neck and shoulder pain, with non-specific radiating right upper extremity pain. There are median sensory deficits in the right hand. None of the reports describe the signs and symptoms of any mental illness. Per the PR2 of 10/13/14, there was neck and shoulder pain, radiating pain in the right arm, and tingling in the hands. The neck was tender and range of motion may have been slightly limited. The shoulder was tender with limited range of motion. The treatment plan included MRIs of the neck and shoulder due to ongoing symptoms. Per the PR2s of 4/17/15, there was ongoing 6/10 pain in the shoulder, upper extremities, and back. Activities of daily living were limited by pain. Shoulder range of motion was slightly limited. A shoulder MRI from 3/10/15 was reviewed. Depression and anxiety were listed but not described. The treatment plans included naproxen, Soma, future urine drug screens, modified work, psychiatric consultation, and cervical spine physical therapy for pain. On 5/22/15 pain was 10/10 and the same signs and symptoms were present. The treatment plan was the same. On 5/11/15, Utilization Review non-certified a psychiatric consultation, a shoulder MRI, physical therapy, and a cervical spine MRI. The MTUS was cited. Note was made of prior MRIs of the neck and shoulder.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Psychiatric Consultation: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Psychological treatment Page(s): 100-102.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation, Chapter 15 Stress Related Conditions Page(s): 22-33, 391-402.

**Decision rationale:** The ACOEM Guidelines pages 22-33 and 391-397 discuss the evaluation of patients in general, and of patients with possible "stress-related conditions". Important history and physical findings are outlined. There is practically none of this sort of information in the available reports. It is not possible to determine medical necessity for a psychiatric referral based on the very brief information presented. As with any other specialist referral, the referring physician is expected to provide a sufficient account of signs and symptoms such that medical necessity is established. Although psychiatric conditions are often multifactorial and complex, the major factors can be outlined by a non-psychiatric physician. The referral is not medically necessary based on lack of sufficient evaluation or evidence of a psychiatric condition.

### **Right shoulder MRI: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), 2015, Shoulder Chapter, MRI.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 200, 207-209.

**Decision rationale:** The MTUS-ACOEM Guidelines, pages 207-9, discuss the criteria for imaging of the shoulder. Special studies are not needed unless there has been a 4-6 week period of conservative care. Exceptions to this rule include the specific bony pathology listed on page 207, and neurovascular compression. Page 200 of the ACOEM Guidelines describes the components of the clinical evaluation of the shoulder. The necessary components of the shoulder examination described in the MTUS are not present. The available reports do not adequately explain the kinds of conservative care already performed. The injured worker currently has non-specific pain, which is not a good basis for performing an MRI. The treating physician has not provided sufficient evidence in support of likely intra-articular pathology or the other conditions listed in the MTUS. The MRI is not medically necessary based on the MTUS recommendations.

### **16 Physical Therapy sessions, 2x/week for 8 weeks, cervical spine: Upheld**

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

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

**Decision rationale:** The treating physician has not provided an adequate prescription, which must contain diagnosis, duration, frequency, and treatment modalities, at minimum. Per the MTUS, Chronic Pain section, functional improvement is the goal rather than the elimination of pain. The maximum recommended quantity of Physical Medicine visits is 10, with progression to home exercise. The treating physician has stated that the current physical therapy prescription is for treating pain. No other reason is given. It is not clear what is intended to be accomplished with this physical therapy, given that it will not cure the pain and there are no other goals of therapy. The current physical therapy prescription exceeds the quantity recommended in the MTUS. No medical reports identify specific functional deficits, or functional expectations for Physical Medicine. The Physical Medicine prescription is not sufficiently specific, and does not adequately focus on functional improvement. Given the completely non-specific prescription for physical therapy in this case, it is presumed that the therapy will use or even rely on passive modalities. Note that the MTUS recommends against therapeutic ultrasound and passive modalities for treating chronic pain. Physical Medicine for chronic pain should be focused on progressive exercise and self-care, with identification of functional deficits and goals, and minimal or no use of passive modalities. A non-specific prescription for "physical therapy" in cases of chronic pain is not sufficient. The Physical Medicine is not medically necessary based on the MTUS, lack of sufficient emphasis on functional improvement, and lack of a sufficient prescription.

**Cervical Spine MRI:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 165, 177-178.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177, 182.

**Decision rationale:** The ACOEM Guidelines 2nd Edition portion of the MTUS provides direction for performing imaging of the spine. Per the MTUS citation above, imaging studies are recommended for "red flag" conditions, physiological evidence of neurological dysfunction, and prior to an invasive procedure. This injured worker had no objective evidence of any of these conditions or indications for an invasive procedure. The treating physician has not documented any specific neurological deficits or other signs of significant pathology. Per the MTUS, imaging is not generally necessary absent a 3-4 week period of conservative care. The treating physician did not describe an adequate course of failed conservative care prior to prescribing an imaging study. The MRI is not medically necessary based on the recommendations in the MTUS.