

Case Number:	CM15-0017727		
Date Assigned:	02/05/2015	Date of Injury:	03/16/2003
Decision Date:	04/03/2015	UR Denial Date:	01/20/2015
Priority:	Standard	Application Received:	01/29/2015

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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 47 year old female who sustained an industrial injury on March 16, 2003. She has reported pain to both shoulders and has been diagnosed with carpal tunnel syndrome, rotator cuff tear left right, and tendinitis shoulder left right. Treatment has included medications and cortisone injection. Currently the injured worker complains of pain in bilateral shoulders left greater than right. The treatment plan included physical therapy, medication and an MRI of the left shoulder. On January 20, 2015 Utilization Review non certified outpatient physiotherapy to the bilateral shoulder 2 x week for 3 weeks and MRI of the left shoulder without contrast citing the MTUS and Official Disability Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physiotherapy for the bilateral shoulders twice a week for three weeks: Upheld

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

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

Decision rationale: The patient was injured on 03/16/03 and presents with pain in both shoulders and difficulty sleeping. The request is for PHYSIOTHERAPY FOR THE BILATERAL SHOULDERS TWICE A WEEK FOR THREE WEEKS. The RFA is dated 01/13/15 and the patient is to return to full duty on 01/09/15. The utilization review letter states that the patient's prior treatment includes physical therapy. MTUS page 98 and 99 has 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 to 10 visits are recommended over 8 weeks, and for neuralgia, neuritis, and radiculitis, 8 to 10 visits are recommended. In this case, the utilization review denial letter indicates that the patient has had prior therapy. There is no indication of how many sessions she had or when these sessions took place. There is no discussion provided on how these sessions impacted the patient's pain and function. There is no indication as to why the patient is not able to establish a home exercise program to manage pain. Therefore, the requested physiotherapy IS NOT medically necessary.

MRI of the left shoulder without contrast: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-208. Decision based on Non-MTUS Citation Official disability guidelines shoulder chapter, MRI.

Decision rationale: The patient was injured on 03/16/03 and presents with pain to both shoulders. The request is for a MRI OF THE LEFT SHOULDER WITHOUT CONTRAST. The utilization review denial rationale is that "there are no positive provocative maneuvers or weakness on the physical exam indicative of significant shoulder pathology to warrant authorization for this MRI." The RFA is dated 01/13/15 and the patient is to return to full work duty on 01/09/15 with no limitations or restrictions. She has a 90 degree should abduction and forward flexion as well as a 60 degree external rotation. Review of the reports provided does not indicate if the patient had a prior MRI of the left shoulder. ACOEM Guidelines has the following regarding shoulder MRI on pages 207-208, "routine testing (laboratory test, plain film radiographs of the shoulder) and more specialized imaging studies are not recommended during the first 6 weeks of activity limitation due to shoulder symptoms except when a red flag noted on history or examination raises suspicion of a serious shoulder condition or referred pain." ACOEM Guidelines page 207-208 continues to state that the primary criteria for ordering imaging studies include: 1. Emergency red flags. 2. Physiologic evidence of tissue insult. 3. Failure to progress in strengthening program. 4. Clarification of anatomy prior to an invasive procedure. The ODG Guidelines under shoulder chapter support MRI of the shoulder if conservative measures have failed and rotator cuff/labral tear are suspected. The patient has been diagnosed with carpal tunnel syndrome, rotator cuff tear left/right, and tendinitis shoulder left/right. It does not appear that the patient had a prior MRI of the left shoulder and there is no indication of any recent surgery. Given that the patient had a limited shoulder range of motion,

and suspicion for rotator cuff pathology, an MRI appears reasonable and supported by the guidelines. The requested MRI of the left shoulder IS medically necessary.