

Case Number:	CM15-0138529		
Date Assigned:	07/29/2015	Date of Injury:	01/09/2013
Decision Date:	09/24/2015	UR Denial Date:	07/08/2015
Priority:	Standard	Application Received:	07/16/2015

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, 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:

The injured worker is a 59 year old female, who sustained an industrial injury on 01/09/2013. She has reported injury to the neck and mid and low back. The diagnoses have included overuse syndrome involving the cervical spine with sprain/strain; thoracic spine with sprain/strain; lumbar spine with sprain/strain; right and left shoulder with sprain/strain; and severe pain-related anxiety and depression, which has caused cardiovascular anomalies overtones with recent bouts of panic disorder and arrhythmias. Treatment to date has included medications, diagnostics, acupuncture, electric shockwave therapy, and physical therapy. Medications have included Naproxen, Cyclobenzaprine, and Prilosec. A progress note from the treating physician, dated 01/06/2015, documented an evaluation with the injured worker. The injured worker reported that she experiences chest pain and palpitations every time she lies down; she has pain in the neck, low back, and both shoulders; and the physical therapy, acupuncture, and electric shockwave therapy she has received have helped her symptoms. Objective findings included moderate to severe distress; decreased cervical spine ranges of motion; there is some tenderness in the thoracic region without spasms; decreased thoracic spine ranges of motion; decreased lumbar spine ranges of motion; and she has some generalized tenderness to the acromioclavicular joint with decreased ranges of motion to both shoulders. The treatment plan has included the request for open MRI for the right shoulder; functional capacity evaluation for the lumbar and the right shoulder; continued physical therapy 2-3 times a week for 6 weeks, 18 visits, for the lumbar spine; continued physical therapy 2-3 times a week for 6 weeks, 18 visits, for the right shoulder; range of motion testing x 1 for the lumbar spine; and range of motion testing x 1 for the right shoulder.

IMR ISSUES, DECISIONS AND RATIONALES

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

Open MRI for the right shoulder: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Magnetic Resonance Imaging.

Decision rationale: The MTUS is silent with regard to specific indications for shoulder MRI. Per the ODG guidelines: Indications for imaging; Magnetic resonance imaging (MRI): Acute shoulder trauma, suspect rotator cuff tear/impingement; over age 40; normal plain radiographs. Subacute shoulder pain, suspect instability/labral tear. Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. (Mays, 2008). Per progress report dated 1/6/15, exam of the bilateral shoulders revealed some generalized tenderness to the AC joint with decreased ranges of motion to both shoulders. She had no neurological deficits to the upper extremities. As the guidelines for MRI are not met, the request is not medically necessary.

Functional Capacity Evaluation for the lumbar and the right shoulder: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Fitness for Work, Functional Capacity Evaluation (FCE).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation Page(s): 21-22.

Decision rationale: The ACOEM Guidelines in regard to FCE detailed the recommendation for consideration of a Functional Capacity Evaluation when necessary to translate medical impairment into functional limitations to determine work capability. The ODG details the recommendation to consider a FCE if the patient has evidence of prior unsuccessful return to work attempts or there is conflicting medical reporting on precautions and/or fitness for a modified job or if the patient's injuries are such that require detailed exploration of the worker's abilities. The documentation submitted for review fails to indicate if the injured worker has had prior unsuccessful return to work attempts, that the injured worker requires a modification for return to work, or that the injured worker has additional injuries which require detailed exploration of the employee's abilities. These are the criteria set forth by the ODG for the consideration of an FCE. As the criteria are not met, the request is not medically necessary.

Continued physical therapy 2-3 times a week for 6 weeks, 18 visits, for the lumbar spine: 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 Medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back 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. The ODG Preface specifies Physical Therapy Guidelines, "There are a number of overall physical therapy philosophies that may not be specifically mentioned within each guideline: (1) As time goes by, one should see an increase in the active regimen of care, a decrease in the passive regimen of care, and a fading of treatment frequency; (2) The exclusive use of "passive care" (e.g., palliative modalities) is not recommended; (3) Home programs should be initiated with the first therapy session and must include ongoing assessments of compliance as well as upgrades to the program; (4) Use of self-directed home therapy will facilitate the fading of treatment frequency, from several visits per week at the initiation of therapy to much less towards the end; (5) 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." 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. Per the guidelines, patients should be formally assessed after a "six-visit clinical trial" to determine whether continuing with physical therapy is appropriate. The injured worker has been previously treated with physical therapy, however, there was no documentation of efficacy supporting continued PT. The request for an additional 18 visits is not appropriate. The request is not medically necessary.

Continued physical therapy 2-3 times a week for 6 weeks, 18 visits, 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 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. Myalgia and myositis, unspecified (ICD9 729.1): 9-10 visits over 8 weeks. Neuralgia, neuritis, and radiculitis, unspecified (ICD 729.2): 8-10 visits over 4 weeks. The ODG Preface specifies Physical Therapy Guidelines, "There are a number of overall physical therapy philosophies that may not be specifically mentioned within each guideline: (1) As time goes by, one should see an increase in the active regimen of care, a decrease in the passive regimen of care, and a fading of treatment frequency; (2) The exclusive use of "passive care" (e.g., palliative modalities) is not recommended; (3) Home programs should be initiated with the first therapy session and must include ongoing assessments of compliance as well as upgrades to the program; (4) Use of self-directed home therapy will facilitate the fading of treatment frequency, from several visits per week at the initiation of therapy to much less towards the end; (5) 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." Per the ODG guidelines: Sprained shoulder; rotator cuff (ICD9 840; 840.4): Medical treatment: 10 visits over 8 weeks. Medical treatment, partial tear: 20 visits over 10 weeks. Post-surgical treatment (RC repair / acromioplasty): 24 visits over 14 weeks. Per the guidelines, patients should be formally assessed after a "six-visit clinical trial" to determine whether continuing with physical therapy is appropriate. The injured worker has been previously treated with physical therapy, however, there was no documentation of efficacy supporting continued PT. The request for an additional 18 visits is not appropriate. The request is not medically necessary.

Range of motion testing x1 for the lumbar spine: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines History and physical examination Page(s): 6.

Decision rationale: Per the MTUS guidelines: Thorough history taking is always important in clinical assessment and treatment planning for the patient with chronic pain, and includes a review of medical records. Clinical recovery may be dependent upon identifying and addressing previously unknown or undocumented medical and/or psychosocial issues. A thorough physical examination is also important to establish/confirm diagnoses and to observe/understand pain behavior. The history and physical examination also serves to establish reassurance and patient confidence. Diagnostic studies should be ordered in this context and not simply for screening purposes. The documentation submitted for review does not contain any discussion, clinical indication or clinical rationale for range of motion testing. The documentation is also unclear as to what "range of motion" testing is. Per progress report dated 1/6/15, physical exam noted ranges of motion of the lumbar spine were as follows: flexion is 35 degrees, extension is 20 degrees, and lateral flexion right and lateral flexion left are 25 degrees. The medical necessity of the request has not been established. The request is not medically necessary.

Range of motion testing x1 for the right shoulder: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist & Hand Computerized Muscle Testing.

Decision rationale: Per the ODG guidelines with regard to computerized muscle testing: Not recommended. There are no studies to support computerized strength testing of the extremities. The extremities have the advantage of comparison to the other side, and there is no useful application of such a potentially sensitive computerized test. Deficit definition is quite adequate with usual exercise equipment given the physiological reality of slight performance variation day to day due to a multitude of factors that always vary human performance. This would be an unneeded test. As the request is not recommended, it is not medically necessary.