

Case Number:	CM15-0168862		
Date Assigned:	09/09/2015	Date of Injury:	03/14/2014
Decision Date:	10/08/2015	UR Denial Date:	08/07/2015
Priority:	Standard	Application Received:	08/27/2015

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: 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 45 year old, male who sustained a work related injury on 3-14-14. The diagnoses have included right shoulder pain, right shoulder internal derangement, right shoulder adhesive capsulitis, lumbar disc herniation, lumbar facet joint pain, lumbar stenosis and chronic low back pain. He is currently being treated for low back and right shoulder pain. Treatments in the past include oral medications and physical therapy (3 sessions). Current treatments are Ibuprofen. Medications he is currently taking Ibuprofen. In the Comprehensive Medical-Legal Evaluation Report dated 7-24-15, the injured worker reports low back, right shoulder and right arm pain. Activities that make pain worse includes prolonged sitting, lifting, doing any activities and lying down. Upon physical exam, he has tenderness to palpation of lumbar paraspinal muscles and right shoulder. Right shoulder range of motion is restricted by pain in all directions and is decreased by 50%. Lumbar range of motion is restricted in all directions by pain. Lumbar flexion is worse than lumbar extension. Lumbar discogenic maneuvers, including pelvic rock and sustained hip flexion were positive bilaterally. Muscle strength is 5 out of 5 except for right deltoid and right biceps which are 4+ out of 5. MRI of lumbar spine dated 7-17-15 notes "L5-S1 moderate to severe bilateral foraminal stenosis, L2-3 through L4-5 mild bilateral foraminal stenosis and transitional lumbosacral segment with the last disc level designated S1-S2 for this report with evidence of partial lumbarization of S1." Right shoulder arthrogram-MRI dated 7-27-15 notes "mild supraspinatus tendinosis with low grade articular and bursal surface fraying. No evidence for transmural rotator cuff tear. Contrast containing fluid seen primarily in the anterior subcutaneous deltoid and subacromial bursa, likely related to injection." He is not working. The

treatment plan includes an orthopedic consultation, additional physical therapy, Pennsaid spray and for x-rays of the right shoulder. The Utilization Review, dated 8-7-15, the request for physical therapy x 10 sessions has been modified to physical therapy to lumbar spine and right shoulder x 7 sessions per CA MTUS guidelines. The request for x-rays of the right shoulder is non-certified at present until the arthrogram-MRI results can be reviewed. The requested treatment for Pennsaid 2% #1 bottle is non-certified due to CA MTUS guidelines that topical medications are largely experimental.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right Shoulder X-ray (2 views): Upheld

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Special Studies.

Decision rationale: The requested Right Shoulder X-ray (2 views), is not medically necessary. American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), Chapter 9, Shoulder Complaints, Special Studies and Diagnostic and Treatment Considerations, Page 207-208, recommend radiographs only with documented red flag conditions, after conservative treatment trials. The injured worker has low back, right shoulder and right arm pain. Activities that make pain worse includes prolonged sitting, lifting, doing any activities and lying down. Upon physical exam, he has tenderness to palpation of lumbar paraspinal muscles and right shoulder. Right shoulder range of motion is restricted by pain in all directions and is decreased by 50%. Lumbar range of motion is restricted in all directions by pain. Lumbar flexion is worse than lumbar extension. Lumbar discogenic maneuvers, including pelvic rock and sustained hip flexion were positive bilaterally. Muscle strength is 5 out of 5 except for right deltoid and right biceps which are 4+ out of 5. Right shoulder arthrogram-MRI dated 7-27-15 notes "mild supraspinatus tendinosis with low grade articular and bursal surface fraying. No evidence for transmural rotator cuff tear. Contrast containing fluid seen primarily in the anterior subcutaneous deltoid and subacromial bursa, likely related to injection." The treating physician has not documented the medical necessity for shoulder x-rays in light of the MR arthrogram results. The criteria noted above not having been met, Right Shoulder X-ray (2 views) is not medically necessary.

Physical Therapy 2x/week x 5 weeks for the Lumbar Spine and Right Shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

Decision rationale: The requested Physical Therapy 2x/week x 5 weeks for the Lumbar Spine and Right Shoulder, is not medically necessary. CA MTUS 2009, Chronic Pain Medical Treatment Guidelines, Physical Medicine, Page 98-99, recommend continued physical therapy with documented objective evidence of derived functional improvement. The injured worker has low back, right shoulder and right arm pain. Activities that make pain worse includes prolonged sitting, lifting, doing any activities and lying down. Upon physical exam, he has tenderness to palpation of lumbar paraspinal muscles and right shoulder. Right shoulder range of motion is restricted by pain in all directions and is decreased by 50%. Lumbar range of motion is restricted in all directions by pain. Lumbar flexion is worse than lumbar extension. Lumbar discogenic maneuvers, including pelvic rock and sustained hip flexion were positive bilaterally. Muscle strength is 5 out of 5 except for right deltoid and right biceps which are 4+ out of 5. Right shoulder arthrogram-MRI dated 7-27-15 notes "mild supraspinatus tendinosis with low grade articular and bursal surface fraying. No evidence for transmural rotator cuff tear. Contrast containing fluid seen primarily in the anterior subcutaneous deltoid and subacromial bursa, likely related to injection." The treating physician has not documented objective evidence of derived functional improvement from completed physical therapy sessions, nor the medical necessity for additional physical therapy to accomplish a transition to a dynamic home exercise program. The criteria noted above not having been met, Physical Therapy 2x/week x 5 weeks for the Lumbar Spine and Right Shoulder is not medically necessary.

Pennsaid 2% #1 bottle: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: The requested Pennsaid 2% #1 bottle, is not medically necessary. CA MTUS Chronic Pain Treatment Guidelines, Topical Analgesics, Non-steroidal anti-inflammatory agents, Page 111-112, recommend topical analgesics with documented osteoarthritis with intolerance to oral anti-inflammatory agents. The injured worker has low back, right shoulder and right arm pain. Activities that make pain worse includes prolonged sitting, lifting, doing any activities and lying down. Upon physical exam, he has tenderness to palpation of lumbar paraspinal muscles and right shoulder. Right shoulder range of motion is restricted by pain in all directions and is decreased by 50%. Lumbar range of motion is restricted in all directions by pain. Lumbar flexion is worse than lumbar extension. Lumbar discogenic maneuvers, including pelvic rock and sustained hip flexion were positive bilaterally. Muscle strength is 5 out of 5 except for right deltoid and right biceps which are 4+ out of 5. Right shoulder arthrogram-MRI dated 7-27-15 notes "mild supraspinatus tendinosis with low grade articular and bursal surface fraying. No evidence for transmural rotator cuff tear. Contrast containing fluid seen primarily in the anterior subcutaneous deltoid and subacromial bursa, likely related to injection." The treating physician has not documented the patient's intolerance of these or similar medications to be taken on an oral basis, nor objective evidence of functional improvement from any previous use. The criteria noted above not having been met, Pennsaid 2% #1 bottle is not medically necessary.