

Case Number:	CM15-0184130		
Date Assigned:	09/24/2015	Date of Injury:	06/25/2001
Decision Date:	11/03/2015	UR Denial Date:	09/03/2015
Priority:	Standard	Application Received:	09/18/2015

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: Iowa, Illinois, California

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & General Preventive 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 62 year old female, who sustained an industrial-work injury on 6-25-01. She reported initial complaints of locking left middle finger, pain in both shoulders, and upper extremities. The injured worker was diagnosed as having rotator cuff syndrome-bilateral shoulders, bilateral carpal tunnel syndrome status post-bilateral carpal tunnel release, and left middle finger and right index finger tenosynovitis. Treatment to date has included medication, diagnostics, and physical therapy. MRI results were reported on the right shoulder on 8-13-09 per the UR to report mild hypertrophic degenerative changes of the acromioclavicular joint along with a mild laterally downward sloping acromion, which mildly impinges upon the supraspinatus muscle, tendinosis and tendinopathy involving the supraspinatus tendon without evidence of a tear. Currently, the injured worker complains of locking of the left middle finger with increased pain with excessive use in gripping. There is pain with use of the upper extremities as well as radiating pain extending down both upper extremities with hand weakness. Pain was rated 7 out of 10. Per the primary physician's progress report (PR-2) on 8-14-15, exam noted right and left shoulder flexion and abduction are limited, tenderness with palpation, tenderness over the left middle finger and right index finger, specifically over the flexor tendon, and diminished sensation for the right hand. Current plan of care includes medication adjustment, hand surgeon follow up, ice-heat application, diagnostic study, and therapy. The Request for Authorization requested service to include Physical therapy evaluation 2 times per week for 8 weeks and MRI bilateral shoulders. The Utilization Review on 9-3-15 denied the request for MRI bilateral shoulders due to lack of a red flag or other new symptoms and

modify Physical Therapy for (6) sessions to demonstrate efficacy, per CA MTUS (California Medical Treatment Utilization Schedule), Chronic Pain Medical Treatment Guidelines 2009; Shoulder Complaints 2004; and ODG (Official Disability Guidelines).

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy evaluation 2 times per week for 8 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines, Preface.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine. Decision based on Non-MTUS Citation Shoulder (Acute & Chronic), Physical Therapy, ODG Preface - Physical Therapy.

Decision rationale: California MTUS guidelines refer to physical medicine guidelines for physical therapy. "Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine." Regarding physical therapy, ODG states "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." At the conclusion of this trial, additional treatment would be assessed based upon documented objective, functional improvement, and appropriate goals for the additional treatment. The request for 16 sessions is far in excess of the initial trials per MTUS and ODG guidelines. As such, the request for Physical therapy evaluation 2 times per week for 8 weeks is not medically necessary.

MRI bilateral shoulders: Upheld

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Special Studies, Summary. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Magnetic resonance imaging (MRI).

Decision rationale: ACOEM states "Primary criteria for ordering imaging studies are: Emergence of a red flag (e.g., indications of intra-abdominal or cardiac problems presenting as shoulder problems). Physiologic evidence of tissue insult or neurovascular dysfunction (e.g., cervical root problems presenting as shoulder pain, weakness from a massive rotator cuff tear, or the presence of edema, cyanosis or Reynaud's phenomenon). Failure to progress in a strengthening program intended to avoid surgery. Clarification of the anatomy prior to an invasive procedure (e.g., a full thickness rotator cuff tear not responding to conservative treatment)." ODG states "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)" The treating physician has not provided evidence of red flags to meet the criteria above. As such the request for MRI bilateral shoulders is not medically necessary.