

<b>Case Number:</b>	CM15-0199162		
<b>Date Assigned:</b>	10/14/2015	<b>Date of Injury:</b>	01/10/2012
<b>Decision Date:</b>	12/24/2015	<b>UR Denial Date:</b>	09/23/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/09/2015

### 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: Internal 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 49 year old female, who sustained an industrial injury on 1-10-2012. The injured worker is being treated for myofascial pain, strain of neck muscle, sacroiliac disorder, and right shoulder impingement. Treatment to date has included diagnostics, medications, and, as of the date of the initial evaluation (not provided), she had received 6 sessions of physical therapy, 6 sessions of chiropractic, 6 sessions of massage and 6 sessions of acupuncture. Per the Primary Treating Physician's Progress Report dated 9-11-2015, the injured worker presented for follow-up. She reported bilateral neck pain and right upper extremity weakness, right sided low back pain, and right wrist and right shoulder pain. Current medications include naproxen and omeprazole. Objective findings included tenderness over the sacroiliac (SI) joints on the right side and trigger points noted over the lower paraspinal. There was no muscle spasm noted. The notes from the provider do not document efficacy of the current treatment. Work status was full duty. The plan of care included, and authorization was requested on 9-11-2015 for 6 sessions of physical therapy for the right shoulder and right sacroiliac joint (SI) joint, magnetic resonance imaging (MRI) right shoulder, right SI joint injection, and transfer of care to pain management specialist. On 9-23-2015, Utilization Review non-certified the request for 6 sessions of physical therapy for the right shoulder and right SI joint, MRI right shoulder, right SI joint injection, transfer of care to pain management specialist.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy x 6 sessions for right shoulder and right SI joint: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter.

**Decision rationale:** MTUS states that active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. As time goes, one should see an increase in the active regimen of care or decrease in the passive regimen of care and a fading of treatment of frequency. When the treatment duration and/or number of visits exceeds the guidelines, exceptional factors should be noted. At the time additional outpatient physical therapy was prescribed, the injured worker had undergone an initial course of physical therapy, chiropractic care and acupuncture. Physician reports fail to show significant objective improvement in pain or function to support the medical necessity for additional physical therapy. The request for Physical therapy x 6 sessions for right shoulder and right SI joint is not medically necessary based on lack of functional improvement and MTUS.

**MRI of the right shoulder: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** MTUS recommends ordering imaging studies when there is evidence of a red flag on physical examination (e.g., indications of intra-abdominal or cardiac problems presenting as shoulder problems), failure to progress in a strengthening program intended to avoid surgery or clarification of the anatomy prior to an invasive procedure (e.g., a full thickness rotator cuff tear not responding to conservative treatment). The injured worker has undergone arthroscopic shoulder surgery and post-operative Physical Therapy with no significant improvement in pain or function. Chart documentation fails to show any red flags or unexplained physical findings on examination that would warrant additional imaging. The request for MRI of the shoulder is not medically necessary by MTUS. The injured worker complains of chronic right shoulder pain. Chart documentation fails to show any red flags or unexplained physical findings on examination that to support the recommendation for MRI. The request for MRI of the right shoulder is not medically necessary by MTUS.

**Right SI joint injection:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Intra-articular Steroid hip injury.

**Decision rationale:** MTUS does not address this request. Per guidelines, hip injections are recommended as an option for short-term pain relief in hip trochanteric bursitis. The treatment is not recommended in early hip osteoarthritis and is under study for moderately advanced or severe hip OA. The injured worker complaints of chronic right sided low back pain with diagnosis of sacroiliac disorder. Documentation fails to demonstrate acute exacerbation of symptoms or diagnosis of bursitis. The medical necessity for SI joint injection has not been established. Per guidelines, the request for Right SI joint injection is not medically necessary.

**Transfer of care to pain management:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Functional restoration programs (FRPs).

**Decision rationale:** Multidisciplinary pain programs or Interdisciplinary rehabilitation programs combine multiple treatments, including physical treatment, medical care and supervision, psychological and behavioral care, psychosocial care, vocational rehabilitation and training and education. Per MTUS guidelines, Outpatient pain rehabilitation programs may be recommended if previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement, if the patient has a significant loss of ability to function independently resulting from the chronic pain and if the patient is not a candidate where surgery or other treatments would clearly be warranted. The injured worker is undergoing treatment for myofascial pain, strain of neck muscle, sacroiliac disorder, and right shoulder impingement. Documentation fails to show a significant loss of ability to function and there is no evidence to support that all other treatment modalities have been recommended and deemed unsuccessful. In the absence of treatment failure and significant loss of function, MTUS guidelines for Pain Management have not been met. The request for Transfer of care to pain management is not medically necessary.