MAXIMUS Federal Services

Case Number:	CM15-0207830		
Date Assigned:	10/26/2015	Date of Injury:	11/04/2014
Decision Date:	12/07/2015	UR Denial Date:	09/21/2015
Priority:	Standard	Application Received:	10/22/2015

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:

This is a 58 year old male who sustained an industrial injury on 11-4-2014. A review of the medical records indicates that the injured worker is undergoing treatment for status post right shoulder arthroscopy, right shoulder acromioclavicular joint arthrosis and rule out right carpal tunnel syndrome and ulnar nerve entrapment neuropathy. Per the progress report dated 6-18-2015, the injured worker had not experienced any improvement since surgery or with therapy. The physician noted that repeat magnetic resonance imaging (MRI) from 6-15-2015 showed no high grade or full thickness cuff tearing or any complications. According to the progress report dated 9-8-2015, the injured worker complained of right hand pain rated 5 out of 10, along with some swelling. He also complained of right shoulder pain that radiated to the mid back rated 6 out of 10. Per the treating physician (9-8-2015), the injured worker was temporarily totally disabled. Objective findings (9-8-2015) revealed weakness of flexion, abduction and external rotation of the right shoulder. There was tenderness to palpation anteriorly and superiorly to the right shoulder. Neer's impingement test and Hawkins-Kennedy impingement were positive on the right. There was decreased grip strength of the right hand. Treatment has included surgery and physical therapy (at least 22 sessions ending in 4-2015). There was also a hand written physical therapy evaluation dated 7-20-2015. The original Utilization Review (UR) (9-21-2015) denied requests for magnetic resonance arthrogram of the right shoulder, diagnostic ultrasound of the right shoulder and 12 physical therapy sessions for the right shoulder.

IMR ISSUES, DECISIONS AND RATIONALES

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

MR Arthrogram of 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: Review indicates the patient is s/p shoulder arthroscopy on 1/30/15 with postop PT. He reports continued symptom complaints without change or functional improvement since the surgery or with PT completed. A repeat MRI of the shoulder had no acute findings or tear. The patient remains on temporary total disability with exam findings of limited shoulder range in all planes, diffuse weakness unspecified without painful arc testing. Per MTUS Treatment Guidelines, criteria for ordering imaging studies are, red flag, physiologic evidence of tissue insult or neurologic dysfunction, failure to progress in a strengthening program intended to avoid surgery, and for clarification of the anatomy prior to an invasive procedure not established here with surgical intervention and repeat MRI without pathological lesion. Clinical report does not demonstrate such criteria and without clear specific evidence to support the diagnostic studies, failed conservative trial, demonstrated specific limited ADL function, acute flare-up, new injury, progressive clinical deterioration or specific surgical lesion, the medical necessity for shoulder MRA has not been established. The MR Arthrogram of right shoulder is not medically necessary or appropriate.

Right shoulder ultrasound: 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) Shoulder, Ultrasound (diagnostic), page 952.

Decision rationale: Criteria for ordering imaging studies such include Emergence of a red flag; Physiologic evidence of tissue insult or neurologic dysfunction; Failure to progress in a strengthening program intended to avoid surgery; Clarification of the anatomy prior to an invasive procedure. Physiologic evidence may be in the form of definitive neurologic findings on physical examination and electrodiagnostic studies. Unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies if symptoms persist; however, review of submitted medical reports have not adequately demonstrated the indication for the ultrasound when recent MRI was unremarkable for acute tear or pathological lesion post surgical intervention. When the neurologic examination is less clear, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. The Right shoulder ultrasound is not medically necessary or appropriate.

Physical therapy sessions x12 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 (ODG), Shoulder (Acute & Chronic): Physical therapy guidelines.

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

Decision rationale: The patient is s/p shoulder arthroscopy on 1/30/15 with at least 22 PT visits rendered. As the surgery is now over 10 months passed, chronic treatment guidelines are applicable. Physical therapy is considered medically necessary when the services require the judgment, knowledge, and skills of a qualified physical therapist due to the complexity and sophistication of the therapy and the physical condition of the patient. However, there is no clear measurable evidence of progress with the PT treatment already rendered including milestones of increased ROM, strength, and functional capacity. Review of submitted physician reports show no evidence of functional benefit, unchanged chronic symptom complaints, clinical findings, and functional status. There is no evidence documenting functional baseline with clear goals to be reached and the patient striving to reach those goals. The Chronic Pain Guidelines allow for visits of physical therapy with fading of treatment to an independent self-directed home program. It appears the employee has received significant therapy sessions without demonstrated evidence of functional improvement to allow for additional therapy treatments. There is no report of acute flare-up, new injuries, or change in symptom or clinical findings to support for formal PT in a patient that has been instructed on a home exercise program for this chronic injury. Submitted reports have not adequately demonstrated the indication to support further physical therapy when prior treatment rendered has not resulted in any functional benefit. The Physical therapy sessions x12 for the right shoulder is not medically necessary or appropriate.