

<b>Case Number:</b>	CM15-0042535		
<b>Date Assigned:</b>	03/12/2015	<b>Date of Injury:</b>	04/11/2012
<b>Decision Date:</b>	05/01/2015	<b>UR Denial Date:</b>	03/05/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/06/2015

### 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: Pennsylvania, Ohio, 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:

The injured worker is a 52 year old male, who sustained an industrial injury on 4/11/2012. He reported falling forward and injuring his right shoulder. The diagnoses have included discogenic cervical condition, shoulder impingement on the right and the left and chronic pain associated with inactivity. Treatment to date has included right shoulder surgery, physical therapy, Transcutaneous Electrical Nerve Stimulation (TENS) unit and medication. According to the progress report dated 2/12/2015, the injured worker complained of difficulty and tightness with regard to the right shoulder. He reported burning discomfort, numbness and tingling along the thumb and index finger. He complained of shooting pain down his left and right arms. Shoulder impingement sign was positive. There was tenderness along the rim of the distal clavicle as well as the rotator cuff on the right. On the left there was some tenderness along the os acromial on the left and tenderness along the rotator cuff and the biceps tendon. Authorization was requested for fluoroscopy neck and left shoulder, right shoulder injection, magnetic resonance angiogram of the right shoulder, 12 sessions of physical therapy for the left shoulder and medications.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Fluoroscopy neck & left shoulder Qty: 1.00: 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), Neck.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209.

**Decision rationale:** ACOEM cautions that relying predominantly on imaging to evaluate the source of shoulder pathology carries a risk of false positive findings. The records in this case do not clearly provide a rationale and differential diagnosis or clinical reasoning to support the requested fluoroscopy procedure. Therefore this request is not medically necessary.

**Physical therapy (Left shoulder) Qty: 12.00:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine Page(s): 98-99.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

**Decision rationale:** MTUS encourages physical therapy with an emphasis on active forms of treatment and patient education. This guideline recommends transition from supervised therapy to active independent home rehabilitation. Given the timeline of this injury and past treatment, the patient would be anticipated to have previously transitioned to such an independent home rehabilitation program. The records do not provide a rationale at this time for additional supervised rather than independent rehabilitation. Additionally the same guidelines support up to 10 visits of therapy for a non-specific physical medicine diagnosis; the records do not provide a rationale for 12 sessions in this case and the request thus exceeds the guidelines for this additional reason. This request is not medically necessary.

**Lidopro ointment 121gm Qty: 1.00:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-113.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

**Decision rationale:** MTUS recommends the use of compounded topical analgesics only if there is documentation of the specific proposed analgesic effect and how it will be useful for the specific therapeutic goal required. The records in this case do not provide such a rationale for this topical medication or its ingredients. Additionally, the same guidelines support use of the component ingredient topical lidocaine only for localized peripheral neuropathic pain, which is not documented in this case. For these multiple reasons, this request is not medically necessary.