

Case Number:	CM15-0046936		
Date Assigned:	03/19/2015	Date of Injury:	03/21/2013
Decision Date:	05/11/2015	UR Denial Date:	03/04/2015
Priority:	Standard	Application Received:	03/12/2015

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:

The injured worker is a 53 year old female, who sustained an industrial injury on 03/21/2013. The injured worker is currently diagnosed as having right shoulder impingement syndrome with acromioclavicular joint arthrosis and rotator cuff tear, bilateral carpal tunnel syndrome, cervical spine strain with degenerative disc disease, thoracic spine strain, lumbar spine strain rule out lumbar radiculopathy, and bilateral elbow medial and lateral epicondylitis. Treatment to date has included right shoulder surgery. In a progress note dated 02/25/2015, the injured worker presented with complaints of left elbow pain, right elbow pain, right shoulder pain, right hand/wrist pain, neck pain, upper/mid back pain, and low back pain. The treating physician reported requesting authorization for MRI of the lumbar spine and additional physical therapy for the right shoulder.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178. Decision based on Non-MTUS Citation Official Disability Guidelines, Lumbar & Thoracic (Acute & Chronic), Magnetic resonance imaging (MRIs).

Decision rationale: Based on the 02/25/15 progress report, the patient presents with neck, back, bilateral elbow, right shoulder and right wrist/hand pain. The patient rates the mid/upper back pain as 7-8/10 and low back pain 4/10. The request is for a MRI lumbar spine. There is no RFA provided and the date of injury is 03/21/13. Diagnoses included lumbar spine strain, rule out lumbar radiculopathy, right cubital tunnel syndrome, mild bilateral carpal tunnel syndrome, right shoulder impingement syndrome, AC arthrosis, partial rotator cuff tear, cervical spine strain with degenerative disc disease and thoracic spine strain. Per 01/14/15 report, physical examination to the lumbar spine revealed increasing pain towards terminal range of motion. The patient is temporarily totally disabled. ACOEM Guidelines, chapter 8, page 177 and 178, state "Unequivocal objective findings that identify specific nerve compromise on the neurological examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option." Official Disability Guidelines do not support MRIs unless there are neurologic signs/symptoms present. Repeat MRI's are indicated only if there has been progression of neurologic deficit. In this case, the available progress reports do not document a prior MRI of the lumbar spine. The provider is requesting for an MRI of the lumbar spine to rule out lumbar radiculopathy. However there were no neurological findings in the provided reports to warrant an image study. The patient only has low back pain with radiating symptoms. There is no suspicion for radiculopathy, any red flags or cauda equina. Official Disability Guidelines support lumbar MRIs only in presence of neurologic signs/symptoms. Therefore, the request IS NOT medically necessary.

Physical therapy 2-3 times a week for 6 weeks: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 28, 27.

Decision rationale: Based on the 02/25/15 progress report, the patient presents with neck, back, bilateral elbow, right shoulder and right wrist/hand pain. The patient is status post right shoulder arthroplasty and right carpal tunnel release on 10/27/14. There is no RFA provided and the date of injury is 03/21/13. There are no physical therapy reports provided for review and the objective response to therapy was not documented in the medical reports. The Utilization review states that a prior review dated 09/11/14 authorized 8 post-operative physical therapy sessions and pre-op clearance. The reviewer denied the request for additional therapy stating that there is no documentation that shows objective functional improvement or progress made with previous course of therapy. For arthroscopic shoulder surgery, the MTUS Postoperative Guidelines page 28 and 27 recommends 24 sessions over 14 weeks. It appears that this patient has participated in 8 post op therapy sessions between 12/8/14 and 01/14/15. On 01/20/15 the treating physician stated that the patient "has persistent residuals" with decreased range of motion and pain and

requested additional therapy. In this case, the requested additional therapy has been prescribed in accordance with MTUS guidelines and IS medically necessary.