

Case Number:	CM14-0127885		
Date Assigned:	09/18/2014	Date of Injury:	11/21/2007
Decision Date:	10/21/2014	UR Denial Date:	07/18/2014
Priority:	Standard	Application Received:	08/11/2014

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 underlying date of injury in this case is 11/21/2007. The date of the utilization review under appeal is 07/08/2014. On 05/02/2014, the patient was seen in primary treating physician followup with regard to symptoms of the cervical spine, lumbar spine, bilateral shoulders, and bilateral arms. The patient complained of neck pain, low back pain, and bilateral shoulder pain as well as bilateral arm pain which had increased and bilateral elbow pain which was unchanged from prior visit. On physical examination, the patient had a normal posture of the head. There was tenderness to palpation over the paracervical muscles without spasm. There was tenderness in the lumbosacral spine more prominent on the right than left. On the right shoulder, Hawkins and Neer's tests were moderately positive, and active range of motion was slightly decreased in flexion and abduction. The treatment plan included physical therapy for the neck, low back, bilateral shoulders, and bilateral elbows including TENS, ultrasound, therapeutic exercises, and massage. Further treatment plan also included an interferential unit at home for pain symptoms. Additionally, a followup MRI with contrast was recommended for the right shoulder to rule out reoccurrence of a rotator cuff tear.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy 2 times a week for 6 weeks to the neck, low back, bilateral shoulder and bilateral elbows: Upheld

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

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

Decision rationale: The Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines section on physical medicine recommends transition to an independent active home rehabilitation. This is a chronic case in which the patient would be expected to have previously transitioned to an independent home rehabilitation program. The records do not provide a rationale instead for additional supervised therapy. This request is not medically necessary.

IF Unit for home use: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 120.

Decision rationale: The Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines section on interferential stimulation states that this is not recommended as an isolated intervention. These guidelines on page 120 recommend the use of interferential stimulation only as a second-line option when the patient has failed initial conservative treatment. The medical records in this case do not indicate the patient has failed initial conservative treatment. Rather, the records outline that the patient continues with conservative treatment including benefit from a TENS unit. In such a situation, the guidelines do not support a rationale or indication for interferential stimulation. This request is not medically necessary.

MRI with IV Contrast Right Shoulder: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Workers' Compensation, Shoulder

Decision rationale: A prior physician review concluded that an MRI with contrast was not indicated because the patient did not have a differential diagnosis of a labral tear, which is the primary indication for MRI arthrography. Official Disability Guidelines/Treatment in Workers' Compensation/Shoulder discusses MRI arthrography and does discuss that this is recommended as an option to treat labral tears. Additionally, MRI arthrography is recommended for suspected re-tear after rotator cuff repair. This patient has ongoing pain and functional limitations in the shoulder with a history of shoulder arthroscopy, and the treating physician has expressed concern

about a possible re-injury to the rotator cuff. This requested treatment is supported by the treatment guidelines. This request is medically necessary.