

Case Number:	CM14-0166679		
Date Assigned:	10/13/2014	Date of Injury:	07/01/2014
Decision Date:	11/13/2014	UR Denial Date:	09/23/2014
Priority:	Standard	Application Received:	10/09/2014

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 injured worker is a 65-year-old male who sustained an injury on 07/01/14. As per the report of 10/08/14, he complained of constant sharp pain to the right shoulder, rated at 7/10. Pain was rated 2/10 on 08/29/14, 3/10 on 09/05/14, 4/10 on 09/30/14 and 7/10 on 10/08/14, which indicated no improvement. PT (physical therapy) was not helping him and shoulder ROM had progressively gotten worse. He had no significant improvement with conservative treatment consisting of NSAIDs, PT, and modified work activities. He stated Ibuprofen does not help; MRA was needed for future management decision. Examination of the right shoulder revealed tenderness over the AC joint, the deltoid and interscapular area. Shoulder motion was painful to all motion. ROM of right shoulder revealed adduction to 20 degrees, internal rotation to 50 degrees and external rotation to 50 degrees. There was positive empty can test. X-ray of the right shoulder dated 08/29/14 revealed mild degenerative change in the shoulder and acromioclavicular joint. Current medications include Voltaren topical gel. Diagnoses include contusion shoulder and injured by slipping, tripping and stumbling. The request for MR Arthrogram-right shoulder was denied and physical therapy-right shoulder quantity: 8: was modified to quantity: 6 on 09/23/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

MR Arthrogram-right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 202-206, 210, 213-214.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder

Decision rationale: According to CA MTUS/ACOEM guidelines, special studies are not needed unless a 4-6 weeks period of conservative care and observation fails to improve symptoms. Per ODG, MR arthrogram is recommended as an option to detect labral tear, full thickness tear or re-tear of rotator cuff repair. In this case, there is no record of a negative MRI in the presence of any red flag signs or symptoms of labral / rotator cuff tear. Therefore, the request is not medically necessary in accordance to guidelines and based on the available clinical information.

Physical therapy-right shoulder Quantity: 8: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Physical Therapy Guidelines

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder

Decision rationale: As per CA MTUS guidelines, physical medicine 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. ODG guidelines allow 10 PT visits over 8 weeks for shoulder pain and impingement syndrome. CA MTUS - Physical Medicine; Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. In this case, there is no record of prior physical therapy progress notes, documenting any significant improvement in the objective measurements (i.e. pain level, range of motion, strength or function) to demonstrate the effectiveness of physical therapy in this injured worker. Furthermore, there is no mention of the patient utilizing an HEP (At this juncture, this patient should be well-versed in an independently applied home exercise program, with which to address residual complaints, and maintain functional levels). There is no evidence of presentation of an acute or new injury with significant findings on examination to warrant any treatments. Additionally, the request for physiotherapy would exceed the guidelines recommendation. Therefore, the request is not medically necessary or appropriate in accordance with the guidelines.