

<b>Case Number:</b>	CM14-0099828		
<b>Date Assigned:</b>	07/30/2014	<b>Date of Injury:</b>	04/02/2011
<b>Decision Date:</b>	09/19/2014	<b>UR Denial Date:</b>	06/11/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/30/2014

### 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 & 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 57-year-old female who reported an injury on 02/02/2011, secondary to heavy lifting. The current diagnoses include cervicothoracic sprain, right shoulder subacromial impingement syndrome, lumbar spine sprain, and rule out right median and ulnar entrapment neuropathy. The latest physician progress report submitted for this review is documented on 07/23/2014. The injured worker presented with complaints of persistent neck and lower back pain, as well as right shoulder and right lower extremity pain. It is noted that the injured worker has been previously treated with medications, acupuncture, epidural steroid injections, and physical therapy. Physical examination revealed muscle spasm in the cervical spine, positive Neer and Hawkin's testing in the right shoulder, positive Phalen's and Durkin's testing in the right hand and wrist, and diminished sensation in the median and ulnar nerve distribution bilaterally. Treatment recommendations included authorization for electrodiagnostic studies, an MRI of the cervical spine thoracic spine, lumbar spine, and right shoulder; as well as physical therapy. There was no request for authorization form submitted for this review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**MRI Cervical Spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

**Decision rationale:** The California MTUS/ACOEM Practice Guidelines state for most patients presenting with true neck or upper back problems, special studies are not needed unless a 3 to 4 week period of conservative care and observation fails to improve symptoms. There was no documentation of a significant musculoskeletal or neurological deficit upon physical examination. There was no evidence of tissue insult or neurological dysfunction. Therefore, the medical necessity has not been established. As such, the request is not medically necessary and appropriate.

**MRI Thoracic Spine:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

**Decision rationale:** The California MTUS/ACOEM Practice Guidelines state if physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test. There was no documentation of significant musculoskeletal or neurological deficit upon physical examination. There was no evidence of tissue insult or neurological dysfunction. Therefore, the medical necessity has not been established. As such, the request is not medically necessary and appropriate.

**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 12 Low Back Complaints Page(s): 303-305.

**Decision rationale:** The California MTUS/ACOEM Practice Guidelines state if physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test. There was no documentation of significant musculoskeletal or neurological deficit upon physical examination. There was no evidence of tissue insult or neurological dysfunction. Therefore, the medical necessity has not been established. As such, the request is not medically necessary and appropriate.

**MRI right shoulder:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints  
Page(s): 207-209.

**Decision rationale:** The California MTUS/ACOEM Practice Guidelines state for most patients presenting with shoulder problems, special studies are not needed unless a 4 to 6 week period of conservative care and observation fails to improve symptoms. There was no documentation of a significant musculoskeletal or neurological deficit. There was no evidence of tissue insult or neurovascular dysfunction. There is no indication that this injured worker is currently a surgical candidate with regard to the right shoulder. As the medical necessity has not been established, the request is not medically necessary and appropriate.

**Physical Therapy 2x6 Cervical Spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

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

**Decision rationale:** The California MTUS Guidelines state California MTUS Guidelines state active therapy 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. As per the documentation submitted, the injured worker's initial date of injury is 02/02/2011. The injured worker has participated in an extensive amount of physical therapy to date. There is no documentation of the previous course of treatment with evidence of objective functional improvement. Therefore, the current request cannot be determined as medically necessary and appropriate.

**Physical Therapy 2x6 Thoracic Spine:** 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 Page(s): 98-99.

**Decision rationale:** The California MTUS Guidelines state California MTUS Guidelines state active therapy 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. As per the documentation submitted, the injured worker's initial date is 02/02/2011. The injured worker has participated in an extensive amount of physical therapy to date. There is no documentation of the previous course of treatment with evidence of objective functional improvement. Therefore, the current request cannot be determined as medically necessary and appropriate.

**Physical Therapy 2x6 Lumbar Spine:** Upheld

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

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

**Decision rationale:** The California MTUS Guidelines state California MTUS Guidelines state active therapy 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. As per the documentation submitted, the injured worker's initial date is 02/02/2011. The injured worker has participated in an extensive amount of physical therapy to date. There is no documentation of the previous course of treatment with evidence of objective functional improvement. Therefore, the current request cannot be determined as medically necessary and appropriate.

**Physical Therapy 2x6 right shoulder:** 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 Page(s): 98-99.

**Decision rationale:** The California MTUS Guidelines state California MTUS Guidelines state active therapy 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. As per the documentation submitted, the injured worker's initial date is 02/02/2011. The injured worker has participated in an extensive amount of physical therapy to date. There is no documentation of the previous course of treatment with evidence of objective functional improvement. Therefore, the current request cannot be determined as medically necessary and appropriate.