Case Number:	CM13-0067841		
Date Assigned:	01/03/2014	Date of Injury:	02/04/2013
Decision Date:	10/13/2015	UR Denial Date:	12/09/2013
Priority:	Standard	Application Received:	12/18/2013

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: New York
Certification(s)/Specialty: Internal Medicine

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 68-year-old female, who sustained an industrial injury on 02-04-2013. She has reported injury to the head, neck, bilateral shoulders, and bilateral wrists. The diagnoses have included blunt head trauma; cephalgia; cervical sprain-strain with underlying degenerative disc disease; left shoulder sprain-strain; right shoulder sprain-strain; bilateral wrist sprain-strain; thoracolumbar sprain-strain with underlying spondylosis-degenerative disc disease; and lumbar spine multilevel spondylosis. Treatment to date has included medications, diagnostics, heat, acupuncture, and chiropractic therapy. Medications have included Motrin, Tramadol, and Vicodin. A progress note from the treating physician, dated 10-18-2013, documented a follow-up visit with the injured worker. The injured worker reported ongoing headaches; constant pain to the neck; there is increased pain to the neck with writing; the bilateral shoulder pain is always present; her right shoulder pain is greater than the left; there is painful and restricted movement of her shoulder joints; bilateral wrist pain is present all the time; low back pain is constant; the back pain increases with walking more than 30 minutes, as well as standing and sitting; she is using a cane; she continues taking pain medication; and she is currently working with restrictions. Objective findings included tenderness to palpation over the midline cervical spine and bilateral trapezius; bilateral shoulder tenderness to palpation over the anterior, lateral, and superior aspect of the shoulders; bilaterally positive Neer and Hawkins tests are carried out; tenderness to palpation over the lumbosacral spine midline; and there is hamstring tightness, bilaterally. The treatment plan has included the request for MRI, right shoulder; and 12 physical therapy sessions (2x6) for the cervical spine, bilateral shoulders, and lumbar spine. The original

utilization review, dated 12-09-2013, non-certified the request for MRI, right shoulder because there does not appear to be a specific differential diagnosis to be evaluated in the shoulder; and non-certified a request for 12 sessions of physical therapy due to failure to demonstrate clear evidence of functional improvement with prior sessions.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI, Right Shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder: MRI.

Decision rationale: According to the ODG, an MRI of the shoulder is indicated for the evaluation of acute shoulder trauma, suspected rotator cuff tear/impingement, in patients over age 40 with normal plain radiographs, sub acute shoulder pain, and suspected instability/labral tear. Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. In this case, the patient has bilateral shoulder pain but there is no documentation of motor weakness in the rotator cuff. There is no documentation of the patient had previous plain films of the right shoulder. Medical necessity for the requested MRI studies has not been established. The requested studies are not medically necessary.

12 Physical Therapy Sessions (2X6) for the Cervical Spine, Bilateral Shoulders and Lumbar Spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

Decision rationale: According to the California MTUS Treatment guidelines, physical therapy (PT) is indicated for the treatment of musculoskeletal pain. 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. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. In this case, the patient has undergone previous physical therapy sessions without noted functional improvement. There is no rationale provided for the requested additional 12 physical therapy sessions for the cervical spine, bilateral shoulders and lumbar spine. Medical necessity for the requested additional physical therapy sessions has not been established. The requested sessions are not medically necessary.