

<b>Case Number:</b>	CM15-0014603		
<b>Date Assigned:</b>	02/02/2015	<b>Date of Injury:</b>	10/09/2012
<b>Decision Date:</b>	03/27/2015	<b>UR Denial Date:</b>	01/16/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/26/2015

### 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, Arizona  
 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 57-year-old male who reported an injury on 10/09/2012. The mechanism of injury was noted as repetitive computer use. His diagnosis was noted as rotator cuff syndrome. His past treatments were noted to include physical therapy, home exercise program, medication, and shoulder injections. His diagnostic studies and surgical history were not provided. During the assessment on 01/14/2015, the injured worker complained of right shoulder pain. He reported moderate right anterior and superior lateral shoulder pain that referred to the neck. He indicated that the pain was made worse with computer use and made better with avoiding arm elevation. The physical examination of the right shoulder revealed no tenderness to palpation in the bicipital groove or over the acromioclavicular joint. Range of motion revealed forward flexion of 180 degrees, abduction of 180 degrees, and internal rotation and external rotation of 80 degrees. There was a positive Hawkins' and Neer's test. His medications were noted to include ibuprofen 400 mg. The treatment plan was to request 6 physical therapy visits to rehab the rotator cuff after the injection and request an MRI of the right shoulder. The rationale for the requested MRI of the right shoulder was not provided. The rationale for the physical therapy for the right shoulder was to rehabilitate the rotator cuff after the injection. The Request for Authorization form was dated 12/11/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Right shoulder MRI:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

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

**Decision rationale:** The request for Right shoulder MRI is not medically necessary. The California MTUS/ACOEM Guidelines indicate that, for most patients with shoulder problems, special studies are not needed unless a 4 to 6 week period of conservative care and observation fails to improve the symptoms. Most patients improve quickly, provided red flag conditions are ruled out. The primary criteria for ordering imaging studies are emergence of a red flag, physiologic evidence of tissue insult or neurovascular dysfunction, failure to progress in a strengthening program intended to avoid surgery, and clarification of the anatomy prior to an invasive procedure. The clinical documentation did not indicate that the injured worker did not respond to a 4 to 6 week period of conservative care and observation. There was no documentation of an emergence of a red flag, physiologic evidence of tissue insult or neurovascular dysfunction, failure to progress in a strengthening program intended to avoid surgery, or clarification of the anatomy prior to an invasive procedure. Given the above, the request is not medically necessary.

**Physical therapy for the right shoulder x6:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-TWC guidelines chapter Shoulder (Acute & Chronic) updated 10/31/14

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

**Decision rationale:** The request for Physical therapy for the right shoulder x6 is not medically necessary. The California MTUS Guidelines note 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. The guidelines recommend up to 10 visits over 8 weeks for myalgia and myositis, unspecified. While the requested 6 visits are within guideline recommendations, there was a lack of documentation indicating whether the injured worker had physical therapy previously with documentation including the number of sessions completed and evidence of significant objective functional improvement with any prior physical therapy. Due to the lack of pertinent information, the request is not medically necessary.