

<b>Case Number:</b>	CM15-0172495		
<b>Date Assigned:</b>	09/14/2015	<b>Date of Injury:</b>	09/25/2014
<b>Decision Date:</b>	10/15/2015	<b>UR Denial Date:</b>	08/19/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/01/2015

### 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: Massachusetts

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

### 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 51 year old male who sustained an industrial injury on September 25, 2014. The doctors first report of illness dated September 29, 2014 reported subjective complaint of lumbar spine pain, right shoulder pain, right knee pain and numbness into the legs. An initial orthopedic evaluation dated April 06, 2015 reported chief subjective complaint of neck, back, shoulder, right elbow, wrist, hand, lower extremity, right knee, and psychiatric complaints. Previous treatment modality to include: activity modification, medications, physical therapy, chiropractic care. Current medication regimen consisted of: Cymbalta, Tylenol and Prilosec. The following diagnoses were applied: lumbar herniated nucleus pulposus; lumbar radiculopathy; cervical radiculopathy, and thoracic spine pain. The plan of care is with recommendation for an orthopedic consultation; nerve conduction study; medications, and undergo a magnetic resonance imaging study of both cervical and thoracic spine. The following noted as current medication regimen: Nabumetone, Duloxetine & Flexeril.

### 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. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) - Indications for imaging - Magnetic resonance imaging (MRI).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder (Acute & Chronic), Magnetic resonance imaging (MRI).

**Decision rationale:** The claimant sustained a work injury occurring in September 2014 and continues to be treated for right shoulder and back pain. An MRI of the right shoulder was done in 2014 with findings of impingement including supraspinatus tendinosis without rotator cuff tear. When seen in February 2015, she was having difficulty sleeping and pain when moving her shoulder. Prior physical therapy had been of no benefit. Physical examination findings included trapezius muscle tenderness and slightly decreased shoulder range of motion. An MRI arthrogram of the right shoulder was requested. New medications were prescribed. In August 2015 prior treatments had included 24 physical therapy and 12 chiropractic sessions with temporary relief. There was cervical and lumbar tenderness with decreased range of motion. There was decreased right upper and lower extremity sensation and decreased right upper extremity strength. Hoffman testing was positive. There was positive right straight leg raising, slumped testing, and Lasegue test. There was right shoulder pain with Spurling's testing. Authorization for physical therapy and follow-up are being requested. The claimant has not worked since March 2015. Magnetic resonance imaging and arthrography of the shoulder have fairly similar diagnostic and therapeutic impact and comparable accuracy. 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 claimant has already had an MRI of the shoulder showing findings of rotator cuff impingement and negative for a rotator cuff tear. A repeat MRI was not medically necessary.

**Physical therapy 2 x week x 6 weeks right shoulder, elbow and knee:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder - Physical therapy guidelines Official Disability Guidelines (ODG), Elbow procedure Official Disability Guidelines (ODG), Knee and Leg procedure Official Disability Guidelines (ODG), Physical therapy/Chiropractic guidelines.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) (1) Chronic pain, Physical medicine treatment. (2) Preface, Physical Therapy Guidelines.

**Decision rationale:** The claimant sustained a work injury occurring in September 2014 and continues to be treated for right shoulder and back pain. An MRI of the right shoulder was done in 2014 with findings of impingement including supraspinatus tendinosis without rotator cuff tear. When seen in February 2015, she was having difficulty sleeping and pain when moving her shoulder. Prior physical therapy had been of no benefit. Physical examination findings included trapezius muscle tenderness and slightly decreased shoulder range of motion. An MRI

arthrogram of the right shoulder was requested. New medications were prescribed. In August 2015 prior treatments had included 24 physical therapy and 12 chiropractic sessions with temporary relief. There was cervical and lumbar tenderness with decreased range of motion. There was decreased right upper and lower extremity sensation and decreased right upper extremity strength. Hoffman testing was positive. There was positive right straight leg raising, slumped testing, and Lasegue test. There was right shoulder pain with Spurling's testing. Authorization for physical therapy and follow-up are being requested. The claimant has not worked since March 2015. The claimant is being treated for chronic pain with no new injury and has already had physical therapy without any benefit. In terms of physical therapy treatment for chronic pain, guidelines recommend a six visit clinical trial with a formal reassessment prior to continuing therapy. In this case, the number of visits requested is in excess of that recommended or what might be needed to determine whether continuation of physical therapy was likely to be any more effective than previously. The request was not medically necessary.

**Follow-up in 6 weeks:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain procedure - Office visits.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic) Office visits.

**Decision rationale:** The claimant sustained a work injury occurring in September 2014 and continues to be treated for right shoulder and back pain. An MRI of the right shoulder was done in 2014 with findings of impingement including supraspinatus tendinosis without rotator cuff tear. When seen in February 2015, she was having difficulty sleeping and pain when moving her shoulder. Prior physical therapy had been of no benefit. Physical examination findings included trapezius muscle tenderness and slightly decreased shoulder range of motion. An MRI arthrogram of the right shoulder was requested. New medications were prescribed. In August 2015 prior treatments had included 24 physical therapy and 12 chiropractic sessions with temporary relief. There was cervical and lumbar tenderness with decreased range of motion. There was decreased right upper and lower extremity sensation and decreased right upper extremity strength. Hoffman testing was positive. There was positive right straight leg raising, slumped testing, and Lasegue test. There was right shoulder pain with Spurling's testing. Authorization for physical therapy and follow-up are being requested. The claimant has not worked since March 2015. Office visits are recommended as determined to be medically necessary. The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The determination is also based on what medications the patient is taking. In this case, the claimant had stopped working 6 months after injury and remains out of work. Medications were prescribed and follow-up to assess her response to treatment is medically necessary.