

<b>Case Number:</b>	CM15-0177921		
<b>Date Assigned:</b>	09/18/2015	<b>Date of Injury:</b>	10/15/2012
<b>Decision Date:</b>	10/21/2015	<b>UR Denial Date:</b>	08/12/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/09/2015

### 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:

This is a 53 year old male with a date of injury of October 15, 2012. A review of the medical records indicates that the injured worker is undergoing treatment for cervical spondylosis without myelopathy, cervical spine stenosis, strain of the rotator cuff capsule, and carpal tunnel syndrome. Medical records dated April 9, 2015 indicate that the injured worker complains of post-injection soreness for two days with slight improvement in shoulder pain, residual left arm numbness, left hand locking, and altered sleep pattern. A progress note dated May 14, 2015 notes subjective complaints of residual bilateral upper extremity pain and persistent altered sleep patterns. The physical exam dated April 9, 2015 reveals increased left shoulder abduction (to 120 degrees), decreased left shoulder flexion (to 120 degrees with pain), and weakly positive anterior shoulder apprehension test. The progress note dated May 14, 2015 did not document a physical examination. Treatment has included shoulder injections, medications (Tylenol #3 and Voltaren gel since at least December of 2014), left shoulder arthroscopic rotator cuff repair (May of 2013), and magnetic resonance imaging of the shoulder (October of 2012) that showed a rotator cuff tear. The original utilization review (August 12, 2015) non-certified a request for magnetic resonance imaging of the left shoulder and six sessions of physical therapy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

## **MRI of the Left Shoulder: Upheld**

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

**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 in October 2012 and continues to be treated for neck and left shoulder pain. The claimant underwent an arthroscopic left rotator cuff repair in May 2013 with a prior scan in October showing findings of a rotator cuff tear. When seen, he was having left shoulder popping. Physical examination findings included decreased cervical spine range of motion with mild paraspinal spasms. There was decreased left shoulder range of motion with negative biceps roll and O'Brien testing. Imaging results of the cervical spine were reviewed. Authorization was requested for a repeat MRI of the left shoulder to rule out a labral tear and for comparison to a scan obtained in 2013. Authorization for six sessions of physical therapy was requested with a goal of decreasing neck pain and increasing flexibility, strength, and functional capacity. Applicable indications in this case for obtaining an MRI of the shoulder include the presence of red flags such as suspicion of cancer or infection or, with subacute shoulder pain, when instability or a labral tear is suspected. In this case, there are no identified red flags and no reported physical examination findings that suggest instability or labral pathology. In terms of a repeat MRI, the scan from 2013 was not reviewed and may explain the claimant's symptoms without a need for a repeat scan. A repeat left shoulder MRI is not medically necessary.

## **Physical Therapy Two (2) Times a Week for Three (3) Weeks: Overturned**

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

**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 in October 2012 and continues to be treated for neck and left shoulder pain. The claimant underwent an arthroscopic left rotator cuff repair in May 2013 with a prior scan in October showing findings of a rotator cuff tear. When seen, he was having left shoulder popping. Physical examination findings included decreased cervical spine range of motion with mild paraspinal spasms. There was decreased left shoulder range of motion with negative biceps roll and O'Brien testing. Imaging results of the cervical spine were reviewed. Authorization was requested for a repeat MRI of the left shoulder to rule out a labral tear and for comparison to a scan obtained in 2013. Authorization for six sessions of physical therapy was requested with a goal of decreasing neck pain and increasing flexibility, strength, and functional capacity. The claimant is being treated for chronic pain. 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 consistent with that recommended and what might be anticipated in terms of achieving the stated goals of treatment and establishing or revising a home exercise program. The request was medically necessary.