

<b>Case Number:</b>	CM15-0045258		
<b>Date Assigned:</b>	04/03/2015	<b>Date of Injury:</b>	01/24/2012
<b>Decision Date:</b>	05/14/2015	<b>UR Denial Date:</b>	02/05/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/10/2015

### 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 36-year-old male who reported an injury on 01/24/2012. The mechanism of injury involved a fall. The current diagnoses include cervical radiculitis, cervical disc syndrome, lumbar disc syndrome, lumbar radiculitis and right shoulder impingement. The injured worker presented for a follow-up evaluation on 12/30/2014. The injured worker reported persistent pain in the cervical spine, right shoulder and lumbar spine. Upon examination of the cervical spine there was limited range of motion with positive extension and rotation bilaterally. Compression test was positive bilaterally. Upon examination of the lumbar spine, there was limited range of motion with positive Kemp's testing and positive straight leg raising bilaterally. Examination of the right shoulder also revealed limited range of motion, painful arc and weakness with flexion and external rotation. Positive Neer's and Hawkins tests, as well as positive impingement sign were also noted. There was 5/5 motor strength in the bilateral upper and lower extremities, intact sensation and normal deep tendon reflexes. Recommendations included an MRI of the right shoulder, cervical and lumbar spine, as well as a course of physical therapy twice per week for 4 weeks. A Request for Authorization form was submitted on 12/30/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Magnetic resonance imaging (MRI) of the cervical spine: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and back chapter, Magnetic resonance imaging (MRI).

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

**Decision rationale:** California MTUS/ACOEM Practice Guidelines state for most patients presenting with true neck and upper back problems special studies are not needed unless a 3 or 4 week period of conservative care and observation fails to improve symptoms. In this case, there was no evidence of the emergence of any red flags. There was no physiologic evidence of tissue insult or nerve impairment. There is also no mention of a failure to progress in a strengthening program. Given the above, the request is not medically appropriate.

**Magnetic resonance imaging (MRI) of the lumbar spine: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low back chapter, Magnetic resonance imaging (MRI).

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

**Decision rationale:** 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. In this case, there was no mention of a failure to respond to conservative management. There was also no documentation of a motor or sensory deficit. The medical necessity for the requested imaging study has not been established in this case. As such, the request is not medically appropriate.

**Magnetic resonance imaging (MRI) of the right shoulder: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder chapter, Magnetic resonance imaging (MRI).

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

**Decision rationale:** California MTUS/ACOEM Practice Guidelines state 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 symptoms. There was no documentation of any red flags or serious pathology. There was no evidence of tissue insult or neurovascular dysfunction. There

was also no evidence of a failure to progress in a strengthening program. Given the above, the request is not medically appropriate.

**Physical therapy for the cervical spine, 2 x 4: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine Page(s): 98.

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

**Decision rationale:** The 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. In this case, there is no information regarding prior physical therapy sessions with documentation of efficacy of the prior treatment. There are no objective functional deficits noted upon examination or baseline measurements to compare to a prior assessment. Given the above, the request is not medically appropriate.

**Physical therapy for the lumbar spine, 2 x 4: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine Page(s): 98.

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

**Decision rationale:** The 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. In this case, there is no information regarding prior physical therapy sessions with documentation of efficacy of the prior treatment. There are no objective functional deficits noted upon examination or baseline measurements to compare to a prior assessment. Given the above, the request is not medically appropriate.

**Physical therapy for the right shoulder 2 x 4: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine Page(s): 98.

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

**Decision rationale:** The 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. In this case, there is

no information regarding prior physical therapy sessions with documentation of efficacy of the prior treatment. There are no objective functional deficits noted upon examination or baseline measurements to compare to a prior assessment. Given the above, the request is not medically appropriate.