

<b>Case Number:</b>	CM15-0070611		
<b>Date Assigned:</b>	04/20/2015	<b>Date of Injury:</b>	07/14/2014
<b>Decision Date:</b>	05/19/2015	<b>UR Denial Date:</b>	03/31/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/14/2015

### 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: North Carolina, Georgia  
Certification(s)/Specialty: Family Practice

### 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 65-year-old male with an industrial injury dated 07/14/2014. His diagnoses included cervical myospasms and left shoulder pain. Prior treatments include medications and "approximately" 25 sessions of physical therapy. Information is taken from the progress note dated 01/29/2015, which is the most current record available in relation to the request, which is dated 03/05/2015. He presents on 01/29/2015 with complaints of constant headaches, neck and left shoulder pain. Neurological examination of the cervical spine was within normal limits. There was tenderness noted of the left shoulder with restricted range of motion. The treating physician documents the injured worker received temporary relief with past physical therapy. Treatment plan included chiropractic treatment and physical therapy to left shoulder. Diagnostic testing (MRI) of the left shoulder was also requested.

### 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:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 214.

**Decision rationale:** ACOEM chapter on shoulder complaints describes that MRI is recommended for pre-operative evaluation of partial or full thickness rotator cuff tears. MRI is not recommended for routine investigation of the shoulder joint for evaluation without surgical indication. The submitted medical records do not describe a concern for rotator cuff tear and do not indicate any plan for surgical intervention. As such, shoulder MRI is not medically necessary.

**Physical therapy for the left shoulder, three times weekly for four weeks:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Section 2 Page(s): 98-99.

**Decision rationale:** The CA MTUS recommends physical therapy for management of chronic pain with a clear preference for active therapy over passive therapy. Physical therapy includes supervision by therapist then the patient is expected to continue active therapies at home in order to maintain improvement levels. Guidelines direct fading treatment frequency from 3 times a week to one or less with guidelines ranging depending on the indication: Myalgia and myositis, unspecified (ICD9 729.1): 9-10 visits over 8 weeks, Neuralgia, neuritis, and radiculitis, unspecified (ICD9 729.2), 8-10 visits over 4 weeks, Reflex sympathetic dystrophy (CRPS) (ICD9 337.2): 24 visits over 16 weeks. In this case, the claimant has already completed multiple physical therapy visits and the medical records indicate that he may be expected to require occasional physical therapy for flare-ups of pain. The records specify that he may need 5-6 visits per flare up. The requested 3 x 4 sessions of PT, exceeds this recommendation and exceeds MTUS guidelines for physical therapy. The request for additional physical therapy sessions is denied. Therefore, the request is not medically necessary.

**Chiropractic for the left shoulder, three times weekly for four weeks:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Section 2 Page(s): 58-60.

**Decision rationale:** The CA MTUS states that manual therapy such as chiropractic manipulation is widely recommended for chronic pain if caused by certain musculoskeletal conditions. It is considered an option for low back pain with a trial of six visits over 2 weeks, which, if there is evidence of functional improvement, can be extended to 18 visits over 6-8 weeks. It is not medically indicated for maintenance or ongoing care. For flares of symptoms, if return to work has been achieved, then 1-2 visits every 4-6 months are indicated. In this case, the request for 3 x 4 visits exceeds the recommended 6 visits over two weeks for initial treatment and is not medically necessary.