

Case Number:	CM15-0075733		
Date Assigned:	04/27/2015	Date of Injury:	07/10/2013
Decision Date:	07/16/2015	UR Denial Date:	04/16/2015
Priority:	Standard	Application Received:	04/21/2015

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

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 46 year old male, who sustained an industrial injury on 7/10/13. The injured worker has complaints of shoulder, neck pain, and lower back and left knee pain. The documentation noted left shoulder tendonitis under left shoulder tendonitis. The diagnoses have included cervical sprain/strain; shoulder muscle spasm and shoulder sprain/strain. Treatment to date has included magnetic resonance imaging (MRI) of the lumbar spine on 12/13/14 showed L3/L4, diffuse disc herniation effaces the thecal sac, disc measures 2.3 millimeter in neutral, 2.2 millimeter in extension/flexion, disc desiccation/dehydration at L3/L4, L4/L5 and L5/S1 (sacroiliac); magnetic resonance imaging (MRI) of the cervical spine on 12/13/14 showed C3/C4, broad based central disc protrusion encroaches the subarachnoid space, disc protrusion and uncovertebral arthrosis compresses the right exiting nerve root and encroaches the left exiting nerve root; physical therapy and injections. The request was for additional physical therapy for the left shoulder, twice weekly for four weeks and left shoulder injection for diagnostic and therapeutic exercises.

IMR ISSUES, DECISIONS AND RATIONALES

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

Additional physical therapy for the left shoulder, twice weekly for four weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98 - 99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine Page(s): 98-99. Decision based on Non-MTUS Citation ODG, Shoulder Complaints Chapter, Physical Therapy.

Decision rationale: Regarding the request for additional physical therapy, Chronic Pain Medical Treatment Guidelines recommend a short course of active therapy with continuation of active therapies at home as an extension of the treatment process in order to maintain improvement levels. ODG has more specific criteria for the ongoing use of physical therapy. ODG recommends a trial of physical therapy. If the trial of physical therapy results in objective functional improvement, as well as ongoing objective treatment goals, then additional therapy may be considered. Within the documentation available for review, there is documentation of completion of 12 prior PT sessions, but there is no documentation of specific objective functional improvement with the previous sessions and remaining deficits that cannot be addressed within the context of an independent home exercise program, yet are expected to improve with formal supervised therapy. A progress note on 12/18/2014 indicated that the patient has failed physical therapy. As such, the currently requested additional physical therapy is not medically necessary.

Left shoulder injection for diagnostic and therapeutic exercises: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 213. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Injections Chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Shoulder Injection Page(s): 204.

Decision rationale: Regarding the request for Shoulder injection, Chronic Pain Medical Treatment Guidelines support the use of a subacromial injection if pain with elevation significantly limits activity following failure of conservative treatment for 2 or 3 weeks. They go on to recommend the total number of injections should be limited to 3 per episode, allowing for assessment of benefits between injections. Official Disability Guidelines recommend performing shoulder injections guided by anatomical landmarks alone. Guidelines go on support the use of corticosteroid injections for adhesive capsulitis, impingement syndrome, or rotator cuff problems which are not controlled adequately by conservative treatment after at least 3 months, when pain interferes with functional activities. Guidelines state that a 2nd injection is not recommended if the 1st has resulted in complete resolution of symptoms, or if there has been no response. Within the documentation available for review, it does not appear the patient had any significant analgesic efficacy or objective functional improvement from the previous shoulder injection. A progress note on 12/18/2014 indicated that the patient has failed cortisone injection of the left shoulder. As such, the currently requested shoulder injection is not medically necessary.

