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| Case Number: | CM15-0091840 | | |
| Date Assigned: | 05/18/2015 | Date of Injury: | 01/12/2014 |
| Decision Date: | 07/07/2015 | UR Denial Date: | 04/20/2015 |
| Priority: | Standard | Application Received: | 05/12/2015 |

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

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 54-year-old female, who sustained an industrial injury on 01/12/2014. She has reported injury to the neck, left shoulder, and back. The diagnoses have included cervical intervertebral disc disorder with myelopathy; lumbar intervertebral disc disorder with myelopathy; rotator cuff syndrome, shoulder; and status post left shoulder arthroscopic surgery. Treatment to date has included medications, diagnostics, and surgical intervention. A progress note from the treating physician, dated 04/10/2015, documented a follow-up visit with the injured worker. Currently, the injured worker complains of left cervical, cervical, right cervical, upper thoracic, left cervical dorsal, left posterior shoulder, right cervical dorsal, right posterior shoulder, left posterior arm, left mid thoracic, left chest, left anterior shoulder, left anterior arm, left anterior elbow, left posterior elbow, left lumbar, left sacroiliac, right lumbar, lumbar, right sacroiliac, left pelvic, left buttock, sacral, left posterior leg, left posterior knee, left calf, left ankle, left foot, left hip, left anterior leg, left anterior knee, left shin, left ankle, and left foot pain; pain is currently rated as an 8/10 on the visual analog scale; numbness and tingling in the left anterior leg, left anterior knee, left shin, left ankle, left foot, left buttock, left posterior leg, left posterior knee, left calf, left ankle, and left foot approximately 50% of the time; and she feels better with activities. Objective findings included palpable tenderness at the cervical, left cervical dorsal, right cervical dorsal, upper thoracic, lumbar, left sacroiliac, right sacroiliac, left buttock, sacral, right buttock, and left anterior shoulder regions; decreased ranges of motion at the cervical spine and left shoulder; and there is positive Patrick Fabere's testing. The treatment plan has included the request for Magnetic Resonance Imaging (MRI) of the left shoulder;

physiotherapy 2 times a week for 3 weeks left shoulder; follow-up in 45 days; and interferential stimulator home unit for chronic pain initial trial 60 days.

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 left shoulder: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-208. Decision based on Non-MTUS Citation Official disability guidelines Shoulder (Acute & Chronic) Chapter, under Magnetic resonance imaging (MRI).

Decision rationale: Based on the 04/10/15 progress report provided by treating physician, the patient presents with left shoulder pain rated 6-8/10. The patient is status post left shoulder surgery, date unspecified. The request is for MAGNETIC RESONANCE IMAGING (MRI) OF THE LEFT SHOULDER. Patient's diagnosis per Request for Authorization form dated 04/10/15 includes intervertebral disc disorder with myelopathy, cervical region. Diagnosis on 04/10/15 included shoulder rotator cuff syndrome. Physical examination to the left shoulder on 04/10/15 revealed well healed surgical scar and decreased range of motion in all planes. The patient is temporarily totally disabled, per sole report dated 04/10/15. ACOEM Guidelines has the following regarding shoulder MRI on pages 207 and 208, routine testing (laboratory test, plain-film radiographs of the shoulder) and more specialized imaging studies are not recommended during the first 6 weeks of activity limitation due to shoulder symptoms, except when a red flag noted on history or examination raises suspicion of serious shoulder condition or referred pain. ODG-TWC, Shoulder (Acute & Chronic) Chapter, under Magnetic resonance imaging (MRI) states: "Indications for imaging, Magnetic resonance imaging (MRI): Acute shoulder trauma, suspect rotator cuff tear/impingement; over age 40; normal plain radiographs; Sub acute shoulder pain, suspect instability/labral tear; Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. (Mays, 2008)" Per 04/10/15 report, treater states "I am requesting MRI of the Left Shoulder as the patient has not had one after her surgery." The patient is status post shoulder surgery; and it does not appear the patient had an updated MRI postoperatively. This request appears reasonable and in accordance with guidelines. Therefore, the request IS medically necessary.

Physiotherapy 2 times a week for 3 weeks left shoulder: Upheld

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

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

Decision rationale: Based on the 04/10/15 progress report provided by treating physician, the patient presents with left shoulder pain rated 6-8/10. The patient is status post left shoulder surgery, date unspecified. The request is for PHYSIOTHERAPY 2 TIMES A WEEK FOR 3 WEEKS LEFT SHOULDER. Patient's diagnosis per Request for Authorization form dated 04/10/15 includes intervertebral disc disorder with myelopathy, cervical region. Diagnosis on 04/10/15 included shoulder rotator cuff syndrome. Physical examination to the left shoulder on 04/10/15 revealed well healed surgical scar and decreased range of motion in all planes. The patient is temporarily totally disabled, per sole report dated 04/10/15. MTUS Chronic Pain Management Guidelines, pages 98, 99 has the following: "Physical Medicine: recommended as indicated below. Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine." MTUS guidelines pages 98, 99 states that for Myalgia and myositis, 9-10 visits are recommended over 8 weeks. For Neuralgia, neuritis, and radiculitis, 8-10 visits are recommended. Per 04/10/15 report, treater states, "I will like the patient to have a course of Physical Therapy to the Left Shoulder 2 times a week for 3 weeks. To help with range of motion." Given patient's diagnosis and continued symptoms, a short course of physical therapy would be indicated by guidelines. However, treater has not provided a precise treatment history, nor documented efficacy of prior therapy. The request for additional physical therapy cannot be warranted without discussion of any flare-ups, explanation of why on-going therapy is needed, or reason patient is unable to transition into a home exercise program. Therefore, the request IS NOT medically necessary.

Follow-up in 45 days: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, 2nd Edition (2004), Independent medical examination and consultations. Ch:7 page 127.

Decision rationale: Based on the 04/10/15 progress report provided by treating physician, the patient presents with pain to left cervical, cervical, right cervical, upper thoracic, left cervical dorsal, left posterior shoulder, right cervical dorsal, right posterior shoulder, left posterior arm, left mid thoracic, left chest, left anterior shoulder, left anterior arm, left anterior elbow, left posterior elbow, left lumbar, left sacroiliac, right lumbar, lumbar, right sacroiliac, left pelvic, left buttock, sacral, left posterior leg, left posterior knee, left calf, left ankle, left foot, left hip, left anterior leg, left anterior knee, left shin, left ankle, and left foot pain, rated 6-8/10. The patient is status post left shoulder surgery, date unspecified. The request is for FOLLOW UP IN 45 DAYS. Patient's diagnosis per Request for Authorization form dated 04/10/15 includes intervertebral disc disorder with myelopathy, cervical region. Diagnosis on 04/10/15 included shoulder rotator cuff syndrome. Physical examination to the left shoulder on 04/10/15 revealed well healed surgical scar and decreased range of motion in all planes. The patient is temporarily totally disabled, per sole report dated 04/10/15. American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) ACOEM guidelines, chapter 7, page 127 state that the occupational health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or

course of care may benefit from additional expertise. A referral may be for consultation to aid in the diagnosis, prognosis, therapeutic management, determination of medical stability, and permanent residual loss and/or the examinee's fitness for return to work. The medical rationale for the request is not clear. Treater has not indicated what body part the consultation was being requested for, either. Due to the limited information provided, the request cannot be considered to be in accordance with the guidelines. Therefore, the request IS NOT medically necessary.

Interferential stimulator home unit for chronic pain initial trial 60 days: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation Page(s): 118-120.

Decision rationale: Based on the 04/10/15 progress report provided by treating physician, the patient presents with pain to left cervical, cervical, right cervical, upper thoracic, left cervical dorsal, left posterior shoulder, right cervical dorsal, right posterior shoulder, left posterior arm, left mid thoracic, left chest, left anterior shoulder, left anterior arm, left anterior elbow, left posterior elbow, left lumbar, left sacroiliac, right lumbar, lumbar, right sacroiliac, left pelvic, left buttock, sacral, left posterior leg, left posterior knee, left calf, left ankle, left foot, left hip, left anterior leg, left anterior knee, left shin, left ankle, and left foot pain, rated 6-8/10. The request is for INTERFERENTIAL STIMULATOR HOME UNIT FOR CHRONIC PAIN INITIAL TRIAL 60 DAYS. Patient's diagnosis per Request for Authorization form dated 04/10/15 includes intervertebral disc disorder with myelopathy, cervical region. Diagnosis on 04/10/15 included shoulder rotator cuff syndrome. Physical examination to the left shoulder on 04/10/15 revealed well healed surgical scar and decreased range of motion in all planes. The patient is temporarily totally disabled, per sole report dated 04/10/15. MTUS pages 118-120, under Interferential Current Stimulation has the following regarding ICS units: "While not recommended as an isolated intervention, Patient selection criteria if Interferential stimulation is to be used anyway: Possibly appropriate for the following conditions if it has documented and proven to be effective as directed or applied by the physician or a provider licensed to provide physical medicine: Pain is ineffectively controlled due to diminished effectiveness of medications; or Pain is ineffectively controlled with medications due to side effects; or History of substance abuse; or Significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment; or Unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.). If those criteria are met, then a one-month trial may be appropriate to permit the physician and physical medicine provider to study the effects and benefits. There should be evidence of increased functional improvement, less reported pain and evidence of medication reduction." Per 04/10/15 report, treater states "I prescribe the IF unit for home use and pain relief purposes." With regards to interferential unit, there is no evidence that pain is not effectively controlled due to the effectiveness of medication, substance abuse or pain due to postoperative conditions or unresponsiveness to conservative measures. MTUS requires 30-day rental with documentation of use and efficacy before a home unit is allowed. There is no documentation that the patient has trialed IF unit for a one-month with documentation of outcomes. This request for Interferential unit purchase is not in accordance with guideline recommendations. Therefore, the request IS NOT medically necessary.