

Case Number:	CM15-0094990		
Date Assigned:	05/21/2015	Date of Injury:	02/26/2014
Decision Date:	06/30/2015	UR Denial Date:	04/09/2015
Priority:	Standard	Application Received:	05/18/2015

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: Internal Medicine

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 57 year old male who sustained an industrial injury on February 26, 2014. He has reported injury to the right shoulder and has been diagnosed with sprain of neck, subsequent encounter, biceps tendon rupture, right, subsequent encounter, and sprain of shoulder, right, subsequent encounter. Treatment has included medical imaging, surgery, sling, medications, physical therapy, and injection. Cervical spine showed tenderness at the anterior cuff. Shoulder abduction was decreased. There was a positive impingement sign. Four view of the cervical spine showed severe neuroforaminal narrowing at C2-3 on the right secondary to facet arthropathy and uncovertebral hypertrophy, moderate degenerative disc disease of the lower cervical spine. The treatment request included Physical therapy for the cervical spine to include traction, isometric, and directionally preference movement two times a week for three weeks, right intra-articular shoulder injection with ultrasound guidance, and MRI of the cervical spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy for the cervical spine to include traction, isometrics, and directionally preferenced movements 2 times a week for 3 weeks;: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy (PT) Physical Medicine Pages 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back (Acute & Chronic) Physical therapy (PT).

Decision rationale: Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines provide physical therapy (PT) physical medicine guidelines. For myalgia and myositis, 9-10 visits are recommended. For neuralgia, neuritis, and radiculitis, 8-10 visits are recommended. X-rays of the cervical spine dated 2/20/15 demonstrated severe neuroforaminal narrowing at C2-3 on the right secondary to facet arthropathy and uncovertebral hypertrophy, and moderate degenerative disc disease of the lower cervical spine. The progress report dated 4/6/15 documented the diagnosis of neck sprain. Physical therapy for the cervical spine two times a week for three weeks (6) was requested. Official Disability Guidelines (ODG) Neck and Upper Back (Acute & Chronic) recommends 9 visits of physical therapy (PT) for cervicgia (neck pain). ODG guidelines support the request for 6 visits of PT physical therapy. Therefore, the request for physical therapy is medically necessary.

Right Intra-Articular Shoulder Injection with ultrasound guidance: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204, 213. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder (Acute & Chronic) Steroid injection.

Decision rationale: Medical Treatment Utilization Schedule (MTUS) addresses shoulder complaints. American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 9 Shoulder Complaints indicates that invasive techniques have limited proven value. If pain with elevation significantly limits activities, a subacromial injection of local anesthetic and a corticosteroid preparation may be indicated after conservative therapy (i.e., strengthening exercises and non-steroidal anti-inflammatory drugs) for two to three weeks. The evidence supporting such an approach is not overwhelming. The total number of injections should be limited to three per episode, allowing for assessment of benefit between injections. Prolonged or frequent use of cortisone injections into the subacromial space or the shoulder joint is not recommended. Official Disability Guidelines (ODG) indicate that glucocorticoid injection for shoulder pain has traditionally been performed guided by anatomical landmarks alone, and that is still recommended. The Cochrane systematic review on this was unable to establish any advantage in terms of pain, function, and shoulder range of motion or safety, of ultrasound-guided glucocorticoid injection for shoulder disorders over either landmark-guided or intramuscular injection. Steroid injections are generally performed without ultrasound guidance. The progress report dated March 30, 2015 documented chronic right shoulder pain secondary to rotator cuff tear status post arthroscopy with continued signs of glenohumeral arthritis, SLAP superior labral anterior and posterior lesion, extensive rotator cuff tendinopathy and subacromial

bursitis. Current medications included Lantus insulin, Glipizide, and Metformin for diabetes mellitus. Right shoulder flexion was 120 degrees, abduction 110 degrees, internal rotation 60 degrees, and external rotation 60 degrees. Right intra-articular shoulder injection with ultrasound guidance was requested. ODG guidelines do not support the request for an ultrasound-guided glucocorticoid injection of shoulder. Therefore, the request for right intra-articular shoulder injection with ultrasound guidance is not medically necessary.

MRI of the cervical spine: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 177-179, 181-183.

Decision rationale: Medical Treatment Utilization Schedule (MTUS) addresses cervical spine MRI magnetic resonance imaging. American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 8 Neck and Upper Back Complaints states that reliance on imaging studies alone to evaluate the source of neck or upper back symptoms carries a significant risk of diagnostic confusion (false-positive test results). Table 8-8 Summary of Recommendations for Evaluating and Managing Neck and Upper Back Complaints (Page 181-183) states that radiography are the initial studies when red flags for fracture, or neurologic deficit associated with acute trauma, tumor, or infection are present. MRI may be recommended to evaluate red-flag diagnoses. Imaging is not recommended in the absence of red flags. MRI may be recommended to validate diagnosis of nerve root compromise, based on clear history and physical examination findings, in preparation for invasive procedure. X-rays of the cervical spine dated 2/20/15 demonstrated severe neuroforaminal narrowing at C2-3 on the right secondary to facet arthropathy and uncovertebral hypertrophy, and moderate degenerative disc disease of the lower cervical spine. Electrodiagnostic studies report dated 1/7/15 documented no evidence of cervical radiculopathy. The progress report dated 4/6/15 documented cervical spine examination. Cervical spine range of motion demonstrated flexion 45/45 degrees, extension 55/55 degrees, rotation 70/70 degrees bilaterally. Right tenderness in trapezius was noted. No spasm was noted. Negative Spurling was noted. Deep tendon reflexes was 2/4 and equal at biceps (C5), brachioradialis (C6) and triceps (C7). Muscle strength was 5/5 and bilaterally equal at biceps, triceps and hand grasp good grip. The progress report dated 4/6/15 documented the diagnosis of neck sprain. Right tenderness in the trapezius was noted. No other cervical tenderness was noted. The physical examination demonstrated full range of motion of the cervical spine. No neurologic deficits were noted. Because red flags were not evidenced, the request for cervical spine magnetic resonance imaging is not supported. Therefore, the request for MRI of the cervical spine is not medically necessary.