MAXIMUS Federal Services

Case Number:	CM13-0042190		
Date Assigned:	12/27/2013	Date of Injury:	07/12/2012
Decision Date:	02/27/2014	UR Denial Date:	10/07/2013
Priority:	Standard	Application Received:	10/17/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine & Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in California. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 48 year old male with a date of injury of 7/12/2012. The injured worker's diagnoses include right glenohumeral labrum tear, rotator cuff syndrome of the right shoulder, and bursitis/tendinitis of the right shoulder. The patient has been conservatively treated with physical therapy, pain medications, and acupuncture. There is documentation of improvement in shoulder range of motion in a note dated December 4, 2013. This note is entitled Akumar Range Of Motion Summary Graph. The disputed issues are a request for an interferential stimulator for the shoulder, physical therapy x 6 session for the shoulder, and a functional capacity evaluation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy and evaluation for the right shoulder (6 sessions): Upheld

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 Medicine Page(s): 98-99.

Decision rationale: In the case of this injured worker, there is documentation of range of motion improvement with physical therapy completed to date. The guidelines recommend that formal

physical therapy be transition to self-directed home exercises. There is no explanation as to why the functional goal of decreasing work restrictions could not be accomplished with an attempt at self-directed home exercises. In a progress note associated with this request on date of service October 24, 2013, there is documentation that range of motion of wrist radial deviation has improved from 24Â° to 34Â°. There is also a detailed report indicating improvement in shoulder range of motion, with graphical representation of the patient's progress in terms of shoulder flexion, abduction, extension, and internal and external rotation. However, there should be more of an emphasis on documenting functional improvement, such as improvement in performance of activities of daily living or a change in work status. Given this lack of documentation of a trial of self-directed home exercises following formal physical therapy, the request for additional physical therapy is recommended for non-certification.

A multi-interferential stimulator for the right shoulder: Overturned

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: The request for interferential stimulation therapy was noted in a progress note dated September 20, 2013. The rationale for interferential stimulation was to decrease muscle spasms. The literature supporting interferential stimulation is very limited and of poor quality as described by the Chronic Pain Medical Treatment Medical Guidelines. However, since this patient continues to have significant pain despite conservative treatment with physical therapy, activity restriction, medications, and acupuncture, a trial of interferential stimulator therapy for 1 month is acceptable as per the California Medical Treatment and Utilization Schedule.

A qualified functional capacity evaluation: Overturned

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Guidelines, Chpater 7, pages 137-138, as well as the Official Disability Guidelines (ODG), Functional Capacity Evaluation.

Decision rationale: In the case of this injured worker, the requesting healthcare provider has felt that a functional capacity evaluation is important to assess the worker's ability to perform in the workplace. It is noted that there are some inaccuracies both on the utilization reviewer's assertions as well as the requesting healthcare provider's. It is not the case that a patient must have previous unsuccessful return to work attempts in order to qualify for a functional capacity evaluation. Rather, the Official Disability Guidelines states that a functional capacity evaluation can be considered if case management has been hampered by issues such as prior unsuccessful return to work attempts. On the other hand, the requesting healthcare care provider does not a

correct citation that the California Medical Treatment and Utilization Schedule states that FCE's should be used to obtain a measure that can be used repeatedly over the course of treatment to demonstrate improvement of function. Rather, the Chronic Pain Medical Treatment Medical Guidelines refers to functional improvement measures as recommended tools that can be used repeatedly over the course of treatment. For this patient there are clear functional deficits despite conservative management. The patient does not have an option of modified work, and the work is documented to be physically demanding in nature. Since the requesting healthcare provider feels a functional capacity evaluation is important in this case, this request is recommended for certification as per ACOEM guidelines.