

<b>Case Number:</b>	CM14-0182557		
<b>Date Assigned:</b>	11/07/2014	<b>Date of Injury:</b>	10/11/2012
<b>Decision Date:</b>	12/12/2014	<b>UR Denial Date:</b>	10/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/03/2014

### 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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Interventional Spine 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 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/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 patient is a 62 year old female with an injury date on 10/11/12. Based on the progress report dated 10/01/2014 the diagnoses included left shoulder status post A/S x 2 and residual pain. According to this report, the patient complains of tenderness at left shoulder joint line pain. Exam findings showed tenderness at bilateral shoulder joints line and blades. The treating physician noted there was a right shoulder partial rotator cuff tear. There were no other significant findings mentioned on this report. The utilization review denied the request on 10/24/14. The requesting provider provided treatment report on 10/01/14.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy 2-3 times a week for 6 weeks:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98,99.

**Decision rationale:** According to the 10/01/14 report, this patient presents with left shoulder pain. The treating physician is requesting physical therapy 2-3 times a week for 6 weeks. For

physical medicine, MTUS guidelines pages 98, 99 state that for myalgia and myositis, 9-10 visits are recommended over 8 weeks. For neuralgia, neuritis, and radiculitis, 8-10 visits are recommended. Review of the report shows no document of patient has had previous physical therapy sessions. In this case, the treating physician has asked for 12 to 18 sessions of therapy for the patient's shoulder. A short course of treatment at this time may be appropriate; however, the request is for 12 -18 visits which exceed what is allowed per MTUS. Therefore, this request is not medically necessary.

**Left shoulder MRI arthrogram:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder (Acute & Chronic) chapter, Surgery for rotator cuff repair

**Decision rationale:** According to the 10/01/14 report, this patient presents with shoulder pain. The treating physician is requesting a left shoulder MRI arthrogram, and stating patient has "tenderness left shoulder joint line." Regarding MRI Arthrogram, Official Disability Guidelines (ODG) state, "Recommended as an option to detect labral tears, and for suspected re-tear post-op rotator cuff repair." Review of reports does not indicate that the patient has had left shoulder surgery to "suspected re-tear post-op rotator cuff repair" or to "detect a labral tears." The treating physician does not mentions why a MRI Arthrogram is needed. Therefore, this request is not medically necessary.

**Functional Capacity Evaluation:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 7, pages 137-139, Functional Capacity Evaluations

**Decision rationale:** According to the 10/01/14 report, this patient presents with bilateral shoulder pain. The treating physician is requesting for Functional Capacity Evaluation (FC). The UR denial letter states there is no clear documentation to certify the request. Regarding Functional/Capacity Evaluation, ACOEM states, "As with any behavior, an individual's performance on an FCE is probably influenced by multiple non-medical factors other than physical impairments. For these reasons, it is problematic to rely solely upon the FCE results for determination of current work capability and restrictions. It is the employer's responsibility to identify and determine whether reasonable accommodations are possible to allow the examinee to perform the essential job activities." In this case, the patient is "able to perform usual work." It is the employer's responsibility to identify and determine whether reasonable accommodations

are possible. Furthermore, the treating physician does not explain why a Functional Capacity Evaluation is needed. Therefore, this request is not medically necessary.