

Case Number:	CM14-0034249		
Date Assigned:	06/20/2014	Date of Injury:	05/04/2011
Decision Date:	08/29/2014	UR Denial Date:	03/05/2014
Priority:	Standard	Application Received:	03/19/2014

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 and is licensed to practice in Illinois. 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 injured worker is a 57-year-old male who reported an injury on 05/04/2011 due to continuous trauma while performing normal job duties. The injured worker reportedly sustained an injury to her right shoulder and right knee ultimately developed a left shoulder pain due to overcompensation. The injured worker's treatment history included right shoulder surgery in 08/2011, corticosteroid injections, physical therapy, activity modification, and multiple medications. The injured worker was evaluated on 02/11/2014. It was documented that the injured worker had persistent right shoulder pain and knee stiffness. Physical findings of the right shoulder documented restricted range of motion secondary to pain with a positive Crank's test and positive O'Brien's test. It is also documented that the injured worker had biceps tendon weakness and pain. Evaluation of the right knee documented restricted range of motion secondary to pain with 2+ joint effusion and a positive bounce test. The injured worker's diagnoses included internal derangement of the knee, joint derangement of the right shoulder, rotator cuff disorder, therapeutic drug monitoring, and long term use of other medications. A request was made for physical therapy, a functional capacity evaluation, and range of motion testing of the right knee and shoulder.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy x12 to the right shoulder: Upheld

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

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

Decision rationale: The requested physical therapy times 12 visits to the right shoulder is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends that injured workers be transitioned into a home exercise program to maintain improvement levels obtained during skilled physical therapy. The clinical documentation fails to provide any evidence that the injured worker is currently participating in a home exercise program. Therefore, a short course of treatment would be indicated in this clinical situation. However, the requested 12 visits would be considered excessive. There are no exceptional factors noted within the documentation or barriers to preclude further progress of the injured worker while participating in a home exercise program. As such, the requested physical therapy times 12 visits for the right shoulder is not medically necessary or appropriate.

FCE (Functional capacity evaluation) for the Right shoulder: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 89-92.

Decision rationale: The requested functional capacity evaluation for the right shoulder is not medically necessary or appropriate. The American College of Occupational and Environmental Medicine recommend a functional capacity evaluation when a more precise delineation between the injured worker's functional capabilities and the ability to participate in functional demand levels of a work environment are required beyond what can be provided during a traditional physical exam. The clinical documentation submitted for review does not provide any evidence that the injured worker has had any failed return to work attempts and would require a more precise level of evaluation such as a functional capacity evaluation to assist with formulating continued treatment planning. Furthermore, there is no indication that the injured worker is at or near maximum medical improvement. As such, the requested functional capacity evaluation for the right shoulder is not medically necessary or appropriate.

ROM (Range of motion) testing to the Right shoulder: 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 Official Disability Guidelines (ODG) Low Back Chapter, Flexibility.

Decision rationale: The requested range of motion testing to the right shoulder is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not address this type of testing. Official Disability Guidelines do not recommend computerized range of motion testing. There is no justification to support the need for this type of testing over what can be provided in a traditional examination setting. As such, the requested range of motion testing to the right shoulder is not medically necessary or appropriate.