

Case Number:	CM14-0068168		
Date Assigned:	09/18/2014	Date of Injury:	06/01/2004
Decision Date:	11/10/2014	UR Denial Date:	05/12/2014
Priority:	Standard	Application Received:	05/13/2014

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 Internal 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 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 65-year-old woman with a date of injury of June 1, 2004. The mechanism of injury is not documented in the medical record that was provided. The IW has been under the care of the treating physician for complete rotator cuff rupture, cervicobrachial syndrome, rotator cuff syndrome, bursitis, shoulder impingement, and frozen shoulder. The most recent evaluation provided is April 3, 2014. The IW complaints of bilateral upper extremity pain that radiates down the right arm to the right hand and from the right side of the head to the neck. She reports her pain as an 8/10, which results in impaired activities of daily living; she also reports symptoms of weakness, headaches, swelling, and trouble sleeping. Physical examination reveals crepitus in the bilateral shoulders with passive internal and external rotation; trigger points palpated in the upper trapezius, lower trapezius, sternocleidomastoid, and splenius capitis bilaterally; Heberden's node of the distal interphalangeal (DIP) joint on bilateral thumbs; left shoulder abduction is 4-/5 and right shoulder abduction is 3+/5; decreased sensation to light touch in the digits 1-2 on the right; and positive Adson's test on the right, positive Hawkin's test bilaterally, and positive Speed's test bilaterally. It is noted that the IW also has muscle spasms in the right shoulder that contribute to the pain, but her range of motion has increased. The treating physician highlights that the IW has had previous surgery on the right shoulder and has utilized a home exercise program and therapist to increase her strength and mobility. It is also documented that the IW is on modified duty and remains "Permanent and Stationary" at work. She has tried a TENS unit (20 to 40% relief) and medications have provided (20 to 40% relief). Overall, the IW states that her symptoms have gotten worse. The current medications have been discontinued according to intolerance according to the April 3, 2014 note: Biofreeze with Ilex Gel, Lodine 400mg, Lyrica 200mg, ██████ Brand Antihistamine, Cyclobenzaprine 7.5mg, and Pantoprazole 20mg. The IW is currently taking Celebrex 50mg. The fact that the IW has been unable to

tolerate most medications has been a challenge. Work Status: The IW is to remain at the modified duty. Sedentary work involves exerting up to 10 pounds of force occasionally or a negligible amount of force frequently to lift, carry, push, pull, or otherwise move objects, including the human body. Sedentary work involves sitting most of the time, but may involve walking or standing for brief periods of time.

IMR ISSUES, DECISIONS AND RATIONALES

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

Functional capacity evaluation: Upheld

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 Official Disability Guidelines (ODG); Functional Capacity Evaluation

Decision rationale: Pursuant to the ACOEM, functional capacity evaluations (FCE) are not medically necessary. FCE can be deliberately simplified based on multiple assumptions and subjective factors which are not always apparent to the requesting physician. There is little scientific evidence confirming functional capacity evaluations predict an individual's actual capacity to perform in the workplace. The functional capacity evaluation does reflect what an individual can do on a single day, at a particular time, under controlled circumstances, that provide an indication of that individual's abilities. As with any behavior performance on a functional capacity evaluation is probably influenced by multiple nonmedical factors other than physical impairments for these reasons, it is problematic to rely solely on the functional capacity evaluation results for determination of current work capacity and restrictions. In this case, there is no documentation as to whether the injured worker was actively participating in a particular job. There was no job description in the medical record other than "modified duty". If a worker is actively participating in determining the suitability of a particular specific job, the FCE is more likely to be successful. Job specific functional capacity evaluations are more helpful than general assessments. Functional capacity evaluations are not suggested for period longer than two weeks without evidence of demonstrated efficacy as demonstrated by subjective and objective gains. There was no mention as to the length of the functional capacity evaluation, and no specifics as to the specific job. Based on the clinical information in the medical record and the peer-reviewed evidence-based guidelines the Functional Capacity Evaluation is not necessary.

Laser therapy to the right shoulder: 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 Low Level Laser Therapy. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG; Low Level Laser Therapy

Decision rationale: Pursuant to the California MTUS Chronic Pain Med Treatment Guidelines, laser therapy to the right shoulder is not medically necessary. The guidelines state laser therapy is not recommended. When applied to the skin, these lasers produce no sensation and do not burn the skin. It is hypothesized that the laser light can penetrate deeply into the tissues where it has a photobiostimulative effect. Given the equivocal or negative outcomes from a significant number of randomized clinical trials it must be concluded that the body of evidence does not allow conclusions other than the treatment of most pain syndromes with low level lasers provides at best the equivalent of a placebo effect. Based on the clinical information in the medical record and the peer-reviewed, evidence-based guidelines laser therapy to the right shoulder is not medically necessary.