

<b>Case Number:</b>	CM14-0070916		
<b>Date Assigned:</b>	07/14/2014	<b>Date of Injury:</b>	02/07/2014
<b>Decision Date:</b>	09/03/2014	<b>UR Denial Date:</b>	04/21/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/16/2014

### 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 Texas and Oklahoma. 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 54-year-old female who reported an injury on 02/07/2014 at [REDACTED] during the performance of her customary job duties as a CT technician. She developed various symptoms including left shoulder pain, headache, sleep disorder, and tendonitis. She reported she developed the left shoulder pain after she was attempting to move a patient. The injured worker's treatment history included physical therapy, x-rays, sleep study, and medications. The injured worker was evaluated on 04/10/2014 and it was documented she complained of constant, moderate left shoulder pain described as numb, dull, and aching. The pain was rated 3/10 on the VAS scale and intermittent in nature. Pain was relieved temporarily with medication. The injured worker also complained of constant, minimal, dull right thumb pain. The thumb freezes. The pain was rated 3/10 on VAS scale and intermittent in nature. The pain was relieved with medication. Grip strength performed using the JAMAR Dynamometer revealed findings of 20/20/20 kg of force on the right and 18/18/18 kg of force on the left. The cervical spine range of motion flexion was 50 degrees, extension/right lateral bend were 40 degrees, right/left rotation were 60 degrees, and left lateral bend was 30 degrees. Foraminal compression and Jackson's compression tests were positive. Tenderness was noted upon palpation of the left biceps, deltoid, rhomboid, and subscapularis muscles in the left AC joint. Shoulder range of motion flexion was 90 degrees, internal/external rotation were 60 degrees, abduction was 120 degrees, and extension was 30 degrees for the left shoulder. The impingement sign and apprehension tests were positive. Tenderness was noted upon palpation of the thenar eminence, carpal bones, and brachioradialis. Wrist range of motion was ulnar/radial deviation were 30 degrees and flexion/extension were 60 degrees on the left. Finkelstein's and Phalen's tests were positive. The treatment plan was to continue care with pain management to address medication needs, acupuncture treatment, begin shockwave therapy for left shoulder, and an

initial Functional Capacity Evaluation. Diagnoses included adhesive capsulitis, rotator cuff syndrome, shoulder sprain/strain, and osteoarthritis of the right thumb. The request for authorization or rationale were not submitted for this review.

### **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 base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines - Treatment in Workers Compensation.

**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, Chronic Pain.

**Decision rationale:** The Official Disability Guidelines state that a Functional Capacity Evaluation is recommended prior to admission to a work hardening program, with reference for assessments tailored to specific task or job. It also states if a worker is actively participating in determining the suitability of a particular job, the Functional Capacity Evaluation is more likely to be successful. A Functional Capacity Evaluation is not effective when the referral is less collaborative and more directive. There is lack of evidence provided on 05/14/2014 as to why the injured worker needs a Functional Capacity Evaluation. There is no evidence of complex issues in the documentation provided preventing the injured worker from returning to work. In addition, there were no outcome measurements indicating the injured worker had failed conservative care such as physical therapy, activity limitations and medication treatment. Given the above, the request for Functional Capacity Evaluation on the injured worker is not medically necessary.

**Acupuncture x 8:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**Decision rationale:** Per the Acupuncture Medical Treatment Guidelines acupuncture is used as an option when pain medication is reduced or not tolerated; it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. Acupuncture can be used to reduce pain, reduce inflammation, increase blood flow, increase range of motion, decrease the side effect of medication-induced nausea, promote relaxation in an anxious patient, and reduce muscle spasm. The clinical documentation indicated that the injured worker previously participated in conservative care, however outcome measurements were not provided for review. In addition, the documents submitted failed to indicate injured worker long-term functional goals. The request submitted failed to indicate location where acupuncture treatment

is required for the injured worker. Given the above, the request for acupuncture X 8 is not medically necessary.

**Shockwave:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines - Treatment in Workers Compensation - Extracorporeal Shockwave Therapy.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Disorders, Extracorporeal Shockwave Therapy.

**Decision rationale:** Per the Acupuncture Medical Treatment Guidelines acupuncture is used as an option when pain medication is reduced or not tolerated; it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. Acupuncture can be used to reduce pain, reduce inflammation, increase blood flow, increase range of motion, decrease the side effect of medication-induced nausea, promote relaxation in an anxious patient, and reduce muscle spasm. The clinical documentation indicated that the injured worker previously participated in conservative care, however outcome measurements were not provided for review. In addition, the documents submitted failed to indicate injured worker long-term functional goals. The request submitted failed to indicate location where acupuncture treatment is required for the injured worker. Given the above, the request for acupuncture X 8 is not medically necessary.