

Case Number:	CM14-0078890		
Date Assigned:	07/18/2014	Date of Injury:	08/19/2011
Decision Date:	10/09/2014	UR Denial Date:	05/15/2014
Priority:	Standard	Application Received:	05/29/2014

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 45-year-old male who reported an injury on 08/19/2011. The injury reported was when the injured worker had reached overhead to clean a stove. His treatments included cortisone injections, medication, surgery, physical therapy, and a TENS unit. The diagnostic testing included an EMG/NCV and an MRI. Within the clinical note dated 04/21/2014, it was reported the injured worker complained of increased left shoulder pain. The injured worker complained of distal upper extremity numbness of his fingers. He rated his pain 5/10 in severity. He complained of pain in the left arm rated 3/10 in severity, radiating into his neck rated 4/10 in severity. On the physical examination, the provider noted the injured worker's cervical spine was 100% of normal forward flexion and 90% of normal left and right rotation. The injured worker had a negative left and right Spurling's test. The injured worker had a negative impingement test and negative Tinel's test. The provider indicated the injured worker had a positive Hoffmann's test bilaterally. The provider indicated the injured worker would benefit from a work hardening program for weakness and limited range of motion of the left shoulder. The Request for Authorization was not submitted for clinical review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Work Hardening 3xWk x 4Wks, Left Shoulder: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Shoulder, Work Conditioning, Work Hardening

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Work Conditioning, Hardening Page(s): 125.

Decision rationale: The request for work hardening 3 times a week for 4 weeks of the left shoulder is not medically necessary. The California MTUS Guidelines recommend work hardening programs as an option depending on the availability of quality programs. The criteria for a work hardening program includes work related musculoskeletal conditions with functional limitations precluding abilities to safely achieve current job demands, which are in the medium or higher demand level clerical/sedentary work. A Functional Capacity Evaluation may be required showing consistent results with maximal effort, demonstrating capabilities below employer verified physical demands. After treatment with an adequate trial of physical or occupational therapy with improvement followed by a plateau, but not likely to benefit from continued physical or occupational therapy or general condition. Not a candidate where surgery or other treatments would clearly be warranted to improve function. Physical and medical recovery sufficient to allow for progressive reactivation and participation for a minimum of 4 hours a day for 3 to 5 days a week. A defined return to work goal agreed to by the employer and employee. A documented specific job to return to with job demands that exceed abilities or documented on the job training. The worker must be able to benefit from the program. Approval of these programs should require a screening process that includes file review, interview, and testing to determine the likelihood of success in a program. The worker must be no more than 2 years past the date of injury. Workers who have not returned to work by 2 years post injury may not benefit. Program timelines include work hardening program should be completed in 4 weeks consecutively or less. It is not supported for longer than 1 to 2 weeks without evidence of patient compliance and demonstrated significant gains as documented by subjective and objective gains and measurable improvement in functional abilities. Upon completion of a rehab program, neither re-enrollment in nor repetition of the same or similar rehabilitation program is medically warranted for the same condition or injury. The Guidelines recommend 10 visits over 8 weeks. The request submitted for 3 times a week for 4 weeks exceeds the Guidelines recommendation that treatment is not supported for longer than 1 to 2 weeks. The injured worker's date of injury was in 2011 which exceeds the Guidelines recommendation that the work must be no more than 2 years past the date of injury. Therefore, the request is not medically necessary.