

<b>Case Number:</b>	CM14-0212436		
<b>Date Assigned:</b>	01/02/2015	<b>Date of Injury:</b>	06/25/2013
<b>Decision Date:</b>	02/28/2015	<b>UR Denial Date:</b>	11/21/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/18/2014

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: California, Hawaii  
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 records indicate the patient is a 38-year-old right-handed woman with two injuries. One is a specific injury of 6/25/13. There is also a cumulative trauma from 2/15/07-11/1/13. She injured her right shoulder in July 2007 and her neck area. She was treated with an injection and continued to work. She underwent arthroscopic surgery on her shoulder in 2014. According to the AME report dated 6/11/14 her complaints were that of constant pain in the right shoulder radiating to the neck area, constant pain in the scapular area, pain in the arm area, weakness in the right upper extremity, pain in the mid back, headaches, and complaints of nausea secondary to medication. Physical exam findings included decreased cervical extension and rotation bilaterally, tenderness right shoulder, tenderness to the right shoulder neck area. Limitation of right shoulder range of motion. Physical therapy made her condition worsen. The attending physician report dated 9/5/14 (76) noted complaints of intermittent right shoulder pain made worse with repetitive movements and overhead activity. Physical exam noted tenderness of the right deltoid. Inability to internally and externally rotate the right shoulder secondary to increasing pain. Orthopedic testing was deferred. The pain is well-controlled with medication. The attending physician report dated 10/1/14 (21) failed to discuss subjective complaints. She noted that the MRI and EMG/NCV studies were regarded as normal. There were no exam findings. She simply wanted to re-evaluate for ROM and after re-evaluation submit a "maximal medical improvement" report. The current diagnoses are: 1. Status post arthroscopic rotator cuff repair 2. Cervical strain secondary to the shoulder surgery 3. Scapular strain secondary to shoulder surgery 4. Mild carpal tunnel syndrome. The utilization review report dated 11/21/14 denied the

request for functional restoration program, Acupuncture (12 sessions, 2 times per week for 6 weeks), and for range of motion and strength testing based on lack of medical necessity.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Functional Restoration Program:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain programs Page(s): 30-32.

**Decision rationale:** The patient has persistent intermittent right shoulder pain made worse with activity. The current request is for Functional Restoration Program. According to the MTUS guidelines, Functional Restoration Programs are recommended when the following criteria are met: (1) An adequate and thorough evaluation has been made, including baseline functional testing so follow-up with the same test can note functional improvement; (2) Previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement; (3) The patient has a significant loss of ability to function independently resulting from the chronic pain; (4) The patient is not a candidate where surgery or other treatments would clearly be warranted (if a goal of treatment is to prevent or avoid controversial or optional surgery, a trial of 10 visits may be implemented to assess whether surgery may be avoided); (5) The patient exhibits motivation to change, and is willing to forgo secondary gains, including disability payments to effect this change; & (6) Negative predictors of success above have been addressed. Based on the records made available for my review, none of the above criteria have been mentioned, let alone met. The attending physician notes that the patient's pain is managed well with current medication. As such, recommendation is for denial.

**Acupuncture (12-sessions, 2 times per week for 6 weeks):** Upheld

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

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

**Decision rationale:** The patient has persistent intermittent right shoulder pain made worse with activity. The current request is for Acupuncture (12-sessions, 2 times per week for 6 weeks) The Acupuncture Medical Treatment Guidelines (AMTG) do recommend acupuncture for the treatment of shoulder complaints. The AMTG states, "Time to produce functional improvement: 3 to 6 treatments." From the records available for review the treating physician is requesting 12 sessions. In this case the request greatly exceeds what the AMTG recommends as a trial to demonstrate functional improvement. As such, recommendation is for denial.

**Range of Motion and Muscle Strength Testing:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-TWC Neck & Upper Back Procedure Summary; Forearm, Wrist & Hand Procedure Summary

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder chapter, Other Medical Treatment Guideline or Medical Evidence: AETNA guidelines

**Decision rationale:** The patient has persistent intermittent right shoulder pain made worse with activity. The current request is for range of motion and strength testing. The ODG shoulder chapter for ROM (Flexibility) does not recommend computerized measures of the shoulder which can be performed using an inclinometer which is reproducible, simple, practical and inexpensive. There is no documentation in the reports provided to indicate the medical necessity for a separate procedure for ROM testing outside of the standard routine part of a physical examination. The MTUS and ODG Guidelines do not address muscle testing. Review of the AETNA Policy guidelines states, "Aetna considers the use of quantitative muscle testing devices experimental and investigational when used for muscle testing because there is insufficient evidence that use of these devices improves the assessment of muscle strength over standard manual strength testing such that clinical outcomes are improved." In this case, there is no clear rationale for the requested range of motion and muscle strength testing. Range of motion and muscle strength testing are part of a routine physical examination and a responsibility of the attending physician in the course of a standard evaluation. As such, recommendation is for denial.