

Case Number:	CM15-0061259		
Date Assigned:	04/07/2015	Date of Injury:	12/13/2013
Decision Date:	05/13/2015	UR Denial Date:	03/05/2015
Priority:	Standard	Application Received:	03/31/2015

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 injured worker (IW) is a 57-year-old male who sustained an industrial injury on 12/13/2013. Diagnoses include status post left shoulder arthroscopic repair of the anterior labral tear/ acromioplasty/partial distal clavicle resection; left shoulder pain; and left biceps sprain/strain. Treatment to date has included medications, injections, left shoulder arthroscopic surgery and physical therapy. Diagnostics performed to date included x-rays and MRIs. According to the report dated 3/9/15, the IW reported left shoulder pain, rated 7/10 to 8/10, which radiated to the biceps, forearm and wrist. On examination, there was tenderness over the left shoulder and left biceps muscle, spasms of the left upper trapezius muscle and atrophy of the left deltoid muscle. The IW stated therapy did not decrease his pain, but improved his functional level and that pain was poorly controlled with medication. A request was made for range of motion and muscle testing of the left shoulder.

IMR ISSUES, DECISIONS AND RATIONALES

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

Range of motion and muscle testing left 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 Chronic Pain Programs Page(s): 30-34. Decision based on Non-MTUS Citation ODG, Shoulder Chapter, Range of Motion.

Decision rationale: The patient presents with neck, left shoulder, arm, hand, and fingers pain. The current request is for Range of motion and muscle testing left shoulder. The treating physician states, "██████ complains of left shoulder pain, which is rated as a 7/10 to an 8/10. He states the pain radiates to the biceps, forearm, and wrist. He reports numbness tingling, pulsating, throbbing, achy, weakness, stiffness, and needles sensation. The pain increases at night when lying down and decreases with pain medication. I am going to request functional restoration 1 time a week for 6 weeks for range of motion and strengthening of the left shoulder." (D.99/C.4) The ODG guidelines state, "Recommended. Range of motion of the shoulder should always be examined in cases of shoulder pain, but an assessment of passive range of motion is not necessary if active range of motion is normal." The MTUS guidelines for functional restoration programs/Chronic Pain Programs require that 6 criteria are addressed and none of those criteria are discussed in the medical records provided. The current request is not medically necessary and the recommendation is for denial.