

<b>Case Number:</b>	CM15-0079015		
<b>Date Assigned:</b>	04/30/2015	<b>Date of Injury:</b>	03/23/2007
<b>Decision Date:</b>	06/02/2015	<b>UR Denial Date:</b>	03/26/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/24/2015

### 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

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This 68 year old female sustained an industrial injury to the neck and left shoulder on 3/23/07. Previous treatment included magnetic resonance imaging, rotator cuff repair with decompression, physical therapy and medications. In a PR-2 dated 2/27/15, the injured worker complained of ongoing left shoulder pain that was aggravated by cold and rainy weather. The injured worker reported improvement to her neck pain. The injured worker rated her pain 5/10 on the visual analog scale. Current diagnoses included right shoulder impingement syndrome, acromial joint arthrosis, partial rotator cuff tear, frozen left shoulder, rotator cuff tendinitis, status post left rotator cuff repair with decompression, cervical spine sprain/strain, cervical spine radiculopathy, left upper extremity neuropathic pain and depression. The treatment plan included physical therapy three times a week for six weeks, medications (Diclofenac XR, Omeprazole and Wellbutrin), and a functional capacity assessment to determine an accurate impairment rating.

### 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:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation ACOEM Guidelines, Chapter 7, page 127.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 7, Pages 137-138 Official Disability Guidelines (ODG), Fitness for Duty Chapter, Functional Capacity Evaluation.

**Decision rationale:** Regarding request for functional capacity evaluation, ACOEM Practice Guidelines state that there is not good evidence that functional capacity evaluations are correlated with a lower frequency of health complaints or injuries. ODG states that functional capacity evaluations are recommended prior to admission to a work hardening program. The criteria for the use of a functional capacity evaluation includes case management being hampered by complex issues such as prior unsuccessful return to work attempts, conflicting medical reporting on precautions and/or fitness for modified job, or injuries that require detailed explanation of a worker's abilities. Additionally, guidelines recommend that the patient be close to or at maximum medical improvement with all key medical reports secured and additional/secondary conditions clarified. Within the documentation available for review, there is no indication that there has been prior unsuccessful return to work attempts, conflicting medical reporting, or injuries that would require detailed exploration. Furthermore, there is a simultaneous request for PT, indicating that the patient's progress may be felt continue per the requesting provider. Given this, the currently requested functional capacity evaluation is not medically necessary.

**Physical therapy 3 times a week for 6 weeks of the left shoulder:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter, Physical Therapy Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 99, Postsurgical Treatment Guidelines Page(s): 26-27.

**Decision rationale:** This worker has had chronic shoulder pain, frozen shoulder (adhesive capsulitis), and is status post subacromial decompression and AC Joint resection. Title 8, California Code of Regulations, section 9792.20 page 26-27 specify the following with regard to post-operative shoulder physical therapy: Adhesive capsulitis (ICD9 726.0): Postsurgical treatment: 24 visits over 14 weeks; Postsurgical physical medicine treatment period: 6 months Rotator cuff syndrome/Impingement syndrome (ICD9 726.1; 726.12): Postsurgical treatment, arthroscopic: 24 visits over 14 weeks; Postsurgical physical medicine treatment period: 6 months. Given that the guidelines permit up to 24 visits of PT in this patient's condition, the request for 18 session of PT post-operatively is medically necessary.