

<b>Case Number:</b>	CM14-0068887		
<b>Date Assigned:</b>	07/11/2014	<b>Date of Injury:</b>	01/07/2014
<b>Decision Date:</b>	09/17/2014	<b>UR Denial Date:</b>	04/23/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/13/2014

### 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 Illinois. 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 56-year-old female who reported an injury on 07/07/2013. The mechanism of injury was noted that, while leaving work and walking in the parking lot, the injured worker was physically attacked and robbed at gunpoint and thrown to the ground. The injured worker's diagnoses included gastritis, cervical spine sprain/strain with myospasms, lumbar spine sprain/strain with myospasms, right shoulder sprain/strain, right hip sprain/strain, right ankle sprain/strain, status post right ankle surgery, and post-traumatic stress disorder. Previous treatment included physical therapy. Diagnostic studies were not provided within the medical records. Surgical history included ankle surgery in 2010 and hysterectomy in 2011. The injured worker complains of on and off upper back pain and rated the pain 6/10. The injured worker reported the pain radiates to her right shoulder and spreads through the upper back with numbness and tingling sensations. The injured worker also complained of low back pain which was rated 5/10. The injured worker reported the pain radiates to her right hip and right outer thigh and denied numbness and tingling sensation. The injured worker also complained of on and off right ankle pain, which was rated at 6/10 to a 7/10. The injured worker reported the pain radiates to her right knee and denied numbness and tingling sensation. The injured worker reported feelings of weakness sensation on the ankle. Additionally, the injured worker noted experiencing tension, sleeplessness, anxiety, depression, tiredness/fatigue, feelings of helplessness, nervousness, and worry about future health and career. The injured worker also expressed fears of death or dying, preoccupation with happenings at work, confused thoughts, poor concentration, and anger. In addition, the injured worker experienced exhaustion, crying spells, mood changes, irritability, withdrawal from family and friends, physical pain, frustration, and loss of interest in usual activities. The objective findings noted the cervical spine revealed tenderness to palpation with spasms of the upper trapezius muscles and suboccipitals bilaterally.

Range of motion of the cervical spine revealed flexion 45/50, extension 30/50, right flexion 30/45, left flexion 30/45, and right/left rotation 60/80. Range of motion of the thoracolumbar spine revealed flexion 45/60, extension 10/25, right flexion 20/25, and left flexion 25/25. The documentation noted the injured worker was positive for straight leg raise on the right at 35 degrees and on the left at 40 degrees. The documentation noted the injured worker had tenderness to palpation with spasms of the upper trapezius muscles and glenohumeral (GH) and acromioclavicular (AC) joints over the right shoulder. Range of motion of the right shoulder revealed flexion 160/180, abduction 160/180, extension 25/50, adduction 20/40, internal rotation 60/80, and external rotation 80/90. The documentation noted the right shoulder was positive on the apprehension sign and strength was 2+/5. The documentation noted the examination of the right hip/thigh revealed tenderness to palpation of the greater trochanter. Range of motion of the right knee revealed flexion, extension, abduction, adduction, internal rotation, and external rotation were all within normal limits, and strength was 2+/5. Physical examination of the right ankle/foot revealed mild to moderate formation and tenderness to palpation and a well-healed surgical scar. Range of motion of the right ankle/foot revealed dorsiflexion 7/11, plantar flexion 17/21, inversion 17/21, and eversion 7/11. The examination noted positive crepitus. Medications included Ibuprofen 800 mg, Diazepam 5 mg, Pantoprazole 20 mg, Zoloft, Xanax, Tramadol, and Soma. The provider requested range of motion and muscle testing. The rationale for the requested treatment plan was not provided within the medical records. The Request for Authorization Form was not provided within the medical records.

### **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:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation Page(s): 33.

**Decision rationale:** The injured worker has a history of upper back pain radiating to the right shoulder and through the upper back with associated numbness and tingling sensation, low back pain which radiates to the right hip and right outer thigh, and right ankle pain which radiates to the right knee. The ACOEM Guidelines state that examining the musculoskeletal system and elements of other organ systems, particularly those involving tenderness, pain, range of motion, or effort are subjective to some extent because the patient's response or interpretation is required for findings on the examination. Some patients with musculoskeletal and other complaints will have no objective findings. The Guidelines also state that a focused medical history, work history, and physical examination generally are sufficient to assess the patient with complaints of an apparently job related disorder. The initial medical history and examination will include evaluation for serious underlying conditions including sources of referred symptoms and other parts of the body. The initial assessment should characterize the frequency, intensity, and duration in this and other equivalent circumstances. In this assessment, certain patient responses and findings raise the suspicion of serious underlying medical conditions. These are referred to

as red flags. Their absence rules out the need for special studies, immediate consultation, referral, or inpatient care during the first 4 weeks of care (not necessarily the first 4 weeks of the worker's condition) when spontaneous recovery is expected as long as associated workplace factors are mitigated. The documentation provided noted the patient complained of pain to the upper back, low back, and right ankle. A complete examination to include range of motion and muscle testing is essential to establish treatment, determine progress in a treatment plan and provide indications for alternative treatments. This documentation is necessary in determining if the patient is moving in a positive direction, no direction, or a negative direction and will play a key role when deciding the course of treatment. Based on the above, the request is medically necessary and appropriate.