

<b>Case Number:</b>	CM14-0185385		
<b>Date Assigned:</b>	11/13/2014	<b>Date of Injury:</b>	09/18/2012
<b>Decision Date:</b>	01/02/2015	<b>UR Denial Date:</b>	10/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/06/2014

### 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 New York. 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 59-year-old male who reported an injury on 09/18/2012. The mechanism of injury was repetitive motion. His diagnoses were noted to include bilateral upper extremity overuse syndrome and bilateral carpal tunnel syndrome, EMG positive. His past treatments were noted to include a home exercise program, physical therapy, chiropractic treatment, medication, work modification, TENS unit, nocturnal volar wrist splints and epidural steroid injections on 03/14/2014. His diagnostic studies were noted to include an EMG/NCV test on 06/20/2014 which revealed bilateral moderate carpal tunnel syndrome with no acute or chronic denervation potentials in any of the muscles tested. His surgical history was noted to include left shoulder debridement on 02/07/2013. During the assessment on 09/17/2014, the injured worker complained of bilateral shoulder and hand pain. The physical examination on 10/16/2014 revealed bilateral positive Phalen's and Tinel's test, bilateral positive compression test of the median nerve with numbness of the thumb, index, and middle finger at approximately 5 seconds, bilateral positive Durkan's test, bilateral positive thenar atrophy, bilateral mild abductor pollicis brevis weakness, bilateral positive prayer sign, bilateral negative Finkelstein's test, and bilateral negative pain over the first dorsal wrist extensor. There was a negative axial grind test bilaterally, no pain in the anatomic snuffbox bilaterally, no pain on ulnar or radial deviation at the wrist bilaterally, no pain on wrist flexion or wrist extension bilaterally, no pain over bilateral lateral epicondyles, no pain over bilateral medial epicondyles, no pain over bilateral antecubital fossas, no pain over bilateral olecranon, no crepitus at the wrist bilaterally, no crepitus at the elbow bilaterally, no evidence of any dorsal or volar wrist masses, no evidence of any dorsal or volar forearm masses, no evidence of any triggers, and no evidence of any spasms. His range of motion in his hands and bilateral wrists and elbows was normal. A current medication list was not provided. The treatment plan was to continue nocturnal volar wrist splints which should be

worn nightly, continue TENS unit, and continue conservative treatment. The rationale for range of motion testing was not provided. The Request for Authorization form was dated 10/16/2014.

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

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

#### **Range of Motion Testing for Right Upper Extremity: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability guidelines

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Flexibility

**Decision rationale:** The request for range of motion testing for right upper extremity is not medically necessary. The Official Disability Guidelines do not recommend flexibility as primary criteria. The relation between back range of motion measures and functional activity is weak or nonexistent and should be part of a routine musculoskeletal evaluation. The guidelines do not recommend computerized measures of the lumbar spine range of motion which can be done with inclinometers and where the result (range of motion) is of unclear therapeutic value. During the assessment on 10/16/2014, the physical examination revealed normal range of motion in the hands and bilateral wrists and elbows. There was no evidence of any triggers or spasms and no pain in the bilateral wrists and elbows. There was a lack of evidence of functional deficits that would warrant the need for further testing. There was no rationale indicating the need for range of motion testing versus the routine musculoskeletal evaluation performed on 10/16/2014. Due to the lack of pertinent information, the request for range of motion testing for the right upper extremity is not medically necessary.