

Case Number:	CM15-0145645		
Date Assigned:	08/06/2015	Date of Injury:	12/04/2013
Decision Date:	09/03/2015	UR Denial Date:	06/23/2015
Priority:	Standard	Application Received:	07/27/2015

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: Maryland

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

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 47-year-old female who sustained an industrial injury on 12/04/2013. The initial report of injury is not found in the medical records reviewed. The injured worker was diagnosed as having: Cervical disc protrusion-cervical myospasm; Cervical pain; Cervical radiculopathy; Cervical sprain/strain; Right shoulder impingement syndrome; Right shoulder pain; Right shoulder sprain-strain; Status post-surgery, right shoulder; Right carpal tunnel syndrome; Right wrist pain; Right wrist sprain-strain; Treatment to date has included right shoulder surgery 2014, physical therapy chiropractic care and medications. Currently, the injured worker complains of constant severe throbbing neck pain and stiffness radiating to the arm rated at an 8 on a scale of 0-10, and aggravated by cold weather. She complains of intermittent moderate stabbing right shoulder pain, situation post right shoulder surgery and aggravated by cold weather. In his right wrist, the worker complains of constant severe, achy right wrist pain aggravated by cold weather and movement and rated as an 8 on a scale of 0-10. On exam, the ranges of motion of the cervical spine are decreased and painful. There is tenderness to palpation of the cervical paravertebral muscles, and muscle spasm of the cervical paravertebral muscles. Cervical compression and Shoulder depression signs are positive. On the right shoulder, there is multiple SHSS present. The ranges of motion are decreased and painful. Tenderness to palpation is present in the acromioclavicular joint, anterior shoulder, lateral shoulder, posterior shoulder and supraspinatus. The right wrist has decreased median nerve sensation with decreased and painful ranges of motion. There is tenderness to palpation of the dorsal wrist, lateral wrist, medial wrist and volar wrist. The treatment plan was for acupuncture, physical therapy, MD consult for medication, and an orthopedic consult. A request for authorization was made for: 1. Medication consultation 2. Range of motion testing one time per month.

IMR ISSUES, DECISIONS AND RATIONALES

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

Medication consultation: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine, Chapter 7, Page 127.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 92. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain- Office visits.

Decision rationale: Medication consultation is not medically necessary per the MTUS ACOEM and the ODG guidelines. The MTUS states that a referral may be appropriate if the practitioner is uncomfortable with the line of inquiry outlined above, with treating a particular cause of delayed recovery or has difficulty obtaining information or agreement to a treatment plan. The ODG states that the need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The documentation is not clear on the need for a medication management consultation. It is unclear why a second physician is necessary for medication management. Without clear rationale in the documentation submitted this request is not medically necessary.

Range of motion testing one time per month: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 200.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 200. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back- Flexibility.

Decision rationale: Range of motion testing one time per month is not medically necessary per the MTUS ACOEM Guidelines and the ODG. The MTUS states that the range of motion of the shoulder should be determined actively and passively. The examiner may determine passive ROM by eliminating gravity in the pendulum position or by using the other arm to aid elevation. The ODG states that the relation between back range of motion measures and functional ability is weak or nonexistent. The request as written does not specify a body part. There are no extenuating circumstances documented as to why the range of motion testing cannot be part of the routine physical exam. The request for range of motion testing monthly is not medically necessary.