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| Case Number: | CM15-0193705 | | |
| Date Assigned: | 10/07/2015 | Date of Injury: | 12/13/2013 |
| Decision Date: | 11/18/2015 | UR Denial Date: | 09/01/2015 |
| Priority: | Standard | Application Received: | 10/01/2015 |

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: Preventive Medicine, Occupational 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 is a 57 year old male, who sustained an industrial injury on 12-13-13. The documentation on 3-9-15 noted that the injured worker has complaints of left shoulder pain that he rates as a 7 out of 10 to an 8 out of 10 on the pain scale. The injured worker states the pain radiates to the biceps, forearm and wrist with numbness, tingling, pulsating, throbbing, achy, weakness, stiffness and needles sensation. The injured worker states the therapy does not help decrease the pain; however, he is able to do more activities of daily living. The documentation noted that there is atrophy of the left deltoid muscle and generalized tenderness to palpation of the entire left shoulder joint and tenderness to palpation with spasms of the upper trapezius muscles and strength was 2+ out of 5. The documentation on 8-18-15 noted that the injured worker has complaints of left shoulder pain that is rates 4 out of 10 that radiates to the biceps, forearm and wrist. The injured worker reports numbness, tingling, pulsating, throbbing, achy, weakness, stiffness and needles sensation. The injured worker reports the pain increases at night when lying down and decreases with pain medications. There is tenderness to palpation of the entire left shoulder joint and tenderness to palpation of the left triceps region. There is limited range of motion secondary to pain and strength is 2+ out of 5. The diagnoses have included sprains and strains of unspecified site of shoulder and upper arm. Treatment to date has included physical therapy; left shoulder arthroscopic repair of the anterior labral tear on 11-21-14; left shoulder arthroscopic acromioplasty on 11-21-14; left shoulder arthroscopic partial distal clavicle resection on 11-21-14; .left shoulder arthroscopy on 6-11-15; and medications. Left shoulder X-ray on 2-23-15 revealed cranial subluxation of the distal clavicle with respect to the

acromion; the above findings are consistent with acromioclavicular separation Rockwood type 1 and degenerative marginal osteophytes off the opposing surfaces of the distal clavicle and the acromion. The original utilization review (9-1-15) non-certified the request for ROM (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:

ROM (range of motion) and muscle testing of the left shoulder: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Workers Compensation (TWC), Internet Version, (updated 07/17/15) Low Back - Lumbar & Thoracic (Acute & Chronic), Flexibility.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Physical Methods, Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Section/Flexibility.

Decision rationale: Per MTUS Guidelines, observing the patient's stance and gait is useful to guide the regional low back examination. In coordination or abnormal use of the extremities may indicate the need for specific neurologic testing. Severe guarding of low-back motion in all planes may add credence to a suspected diagnosis of spinal or intrathecal infection, tumor, or fracture. However, because of the marked variation among persons with symptoms and those without, range-of-motion measurements of the low back are of limited value. Per ODG, the use of range of motion testing is not recommended as a primary criterion, but should be a part of a routine musculoskeletal evaluation. The relation between lumbar range of motion measures and functional ability is weak or nonexistent. This has implications for clinical practice as it relates to disability determination for patients with chronic low back pain, and perhaps for the current impairment guidelines of the American Medical Association. The value of the sit-and-reach test as an indicator of previous back discomfort is questionable. The AMA Guides to the Evaluation of Permanent Impairment, 5th edition, state, "an inclinometer is the preferred device for obtaining accurate, reproducible measurements in a simple, practical and inexpensive way." (p 400) They do not recommend computerized measures of lumbar spine range of motion which can be done with inclinometers, and where the result (range of motion) is of unclear therapeutic value. ROM testing should be a part of a routine musculoskeletal evaluation, therefore, the request for ROM (range of motion) and muscle testing of the left shoulder is not medically necessary.