

| | | | |
|-----------------------|--------------|------------------------------|------------|
| Case Number: | CM15-0086694 | | |
| Date Assigned: | 05/08/2015 | Date of Injury: | 10/27/2004 |
| Decision Date: | 06/22/2015 | UR Denial Date: | 04/07/2015 |
| Priority: | Standard | Application Received: | 05/05/2015 |

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

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 55 year old female, who sustained an industrial injury on 10/24/2004. She has reported subsequent bilateral shoulder pain and was diagnosed with bilateral shoulder impingement, residuals of the left shoulder after prior surgery, right shoulder partial thickness rotator cuff tear and right shoulder osteoarthritis and tendinosis. Treatment to date has included oral pain medication, home exercise program and physical therapy. In a progress note dated 10/13/2014, the injured worker complained of increased pain in the right shoulder. Objective findings were notable for decreased range of motion of the cervical spine with spasm, positive Spurling's test on the left side, decreased range of motion in flexion and abduction of the left shoulder and positive Neer's and Hawkin's tests of the left shoulder. A request for authorization of range of motion tests was submitted. There was no medical documentation submitted that pertains to the current treatment request.

IMR ISSUES, DECISIONS AND RATIONALES

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

Range of Motion Testing: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Functional improvement measures Page(s): 48. Decision based on Non-MTUS Citation Official

Disability Guidelines (ODG-TWC), Forearm, Wrist, & Hand Procedure Summary, Computerized Muscle Testing.

MAXIMUS guideline: Decision based on MTUS ACOEM Page(s): Chapter 7, Independent Medical Examinations and Consultations, pages 137-138.

Decision rationale: Computerized ROM testing is not supported by MTUS, ODG, or AMA Guides. Evaluation of range of motion and motor strength are elementary components of any physical examination for musculoskeletal complaints and does not require computerized equipment. In addition, per ODG, for example, the relation between range of motion measurements and functional ability is weak or even nonexistent with the value of such tests like the sit-and-reach test as an indicator of previous spine discomfort is questionable. They specifically noted computerized measurements to be of unclear therapeutic value. Medical necessity for computerized strength and ROM outside recommendations from the Guidelines has not been established. The Range of Motion Testing is not medically necessary or appropriate.