

Case Number:	CM14-0145720		
Date Assigned:	09/12/2014	Date of Injury:	09/12/2012
Decision Date:	10/30/2014	UR Denial Date:	08/26/2014
Priority:	Standard	Application Received:	09/08/2014

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 50-year-old female with a reported date of injury on 09/12/2012. The mechanism of injury was not listed in the records. The diagnoses included right shoulder pain. The past treatments included pain medication and physical therapy. There was no relevant diagnostic imaging submitted for review. There was no relevant surgical history documented in the records. The subjective complaints on 07/17/2014 included right shoulder, left shoulder, right wrist, left wrist, right hand, left hand, right ankle, and left ankle pain. The physical examination noted slight decreased range of motion to the right shoulder, left shoulder, right wrist, left wrist. The medications included Cyclobenzaprine/Tramadol/Flurbiprofen cream and Capsaicin/Flurbiprofen/Tramadol/Menthol/Camphor Cream. The treatment plan was to order physical therapy; EMG test; and muscle test, 2 limbs. A request was received for muscle test, 2 limbs. The rationale for the request was not provided. The Request for Authorization form was not provided within the records submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

MUSCLE TEST 2 LIMBS: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 123-125, Chronic Pain Treatment Guidelines Page(s): 98-99.

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

Decision rationale: The request for muscle test, 2 limbs is not medically necessary. The injured worker has chronic upper extremity pain. The Official Disability Guidelines state that flexibility tests are not recommended as primary criteria. Additionally, there was no rationale provided as to why the muscle test is required. As the requested test is not supported by the evidence based guidelines, the request is not supported. As such, the request is not medically necessary.