

<b>Case Number:</b>	CM15-0074294		
<b>Date Assigned:</b>	05/04/2015	<b>Date of Injury:</b>	08/22/2013
<b>Decision Date:</b>	06/02/2015	<b>UR Denial Date:</b>	03/31/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/20/2015

### 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, Indiana, New York  
Certification(s)/Specialty: Internal 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 52 year old female, who sustained an industrial injury on August 22, 2013. She reported left hand and left shoulder pain after falling from a chair she was standing on. The injured worker was diagnosed as having lumbar musculoligamentous injury, lumbar muscle spasm, left shoulder myoligamentous injury, left shoulder muscle spasm, status post left TFCC repair, status post left ulnar styloid ORIF and loss of sleep. Treatment to date has included diagnostic studies, surgical intervention, a morphine injection, left hand casting, physical therapy, medications and work restrictions. Currently, the injured worker complains of low back pain, left shoulder pain, stiffness, and weakness radiating to the left arm, left wrist pain, stiffness, numbness and weakness radiating to the hand and finger with numbness of the ring and pinky finger. The injured worker reported an industrial injury in 2013, resulting in the above noted pain. She was treated conservatively and surgically without complete resolution of the pain. Evaluation on July 3, 2014, revealed continued pain as noted. Evaluation on October 21, 2014, revealed continued pain as noted. Physical therapy of the left shoulder and a range of motion test was requested.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Range of Motion Test:** 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), Low Back Chapter, Flexibility.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder section, Range of motion testing.

**Decision rationale:** Pursuant to the Official Disability Guidelines, range of motion test is not medically necessary. Computerized range of motion (flexibility) is not recommended as a primary criterion, but should be part of a routine musculoskeletal evaluation. The relation between lumbar range of motion measures and functional abilities were nonexistent. This has implications for clinical practice as it relates to disability determinations for patients with chronic low back pain. In this case, the injured workers working diagnosis is that is both intra-articular fracture status post open reduction internal fixation left wrist. The request for authorization was dated March 16, 2015. The most recent progress note in the medical record is a QME dated October 21, 2014. There are no contemporaneous progress notes on or about request authorization date of March 16, 2015. The QME addresses the primary complaint referable to the left wrist. The worker had an open reduction internal fixation and received 24 sessions of physical therapy. There is documentation about left shoulder pain and pending physical therapy. Range of motion testing is part of the routine musculoskeletal physical examination. There is no clinical rationale to perform range of motion testing outside the realm of the physical examination. Consequently, absent guideline recommendations for range of motion testing, range of motion testing is not medically necessary.

**Physical Therapy 2-3 x 6 for the Left Shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder section, Physical therapy.

**Decision rationale:** Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, physical therapy 2 to 3 times per week times six weeks to the left shoulder is not medically necessary. Patients should be formally assessed after a six visit clinical trial to see if the patient is moving in a positive direction, no direction or negative direction (prior to continuing with physical therapy). When treatment duration and/or number of visits exceeds the guideline, exceptional factors should be noted. In this case, the injured worker's working diagnosis is that is both intra-articular fracture status post open reduction internal fixation left wrist. The request for authorization was dated March 16, 2015. The most recent progress note in the medical record is a QME dated October 21, 2014. There are no contemporaneous progress notes on or about request authorization date of March 16, 2015. The QME addresses the primary complaint referable to the left wrist. The worker had an open reduction internal fixation and

received 24 sessions of physical therapy. There is documentation about left shoulder pain and pending physical therapy. There is no clinical indication or rationale in the medical record for 12 to 18 sessions of physical therapy. Additionally, patients should be formally assessed after a six visit clinical trial. There is insufficient information to make a proper determination based on the absence of a contemporaneous progress note on or about the request for authorization. Consequently, absent clinical documentation with a clinical indication and rationale for physical therapy to the left shoulder with guideline recommendations for a six visit clinical trial, physical therapy 2 to 3 times per week times six weeks to the left shoulder is not medically necessary.