

Case Number:	CM14-0064971		
Date Assigned:	07/11/2014	Date of Injury:	10/05/1992
Decision Date:	09/10/2014	UR Denial Date:	04/08/2014
Priority:	Standard	Application Received:	05/08/2014

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 Emergency Medicine and is licensed to practice in California. 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 60 year-old female, who sustained an injury on October 5, 1992. The mechanism of injury is not noted. Pertinent diagnostics are not noted. Treatments have included: medications, acupuncture, lumbar laminectomy/discectomy. The current diagnoses are: low back pain, s/p lumbar laminectomy/discectomy with acute exacerbation, epidural steroid injections. The stated purpose of the request for Retrospective review of range of motion testing for the lumbar spine (DOS 03/12/14) was not noted. The request for Retrospective review of range of motion testing for the lumbar spine (DOS 03/12/14) was denied on April 8, 2014, noting that referenced guidelines do not recommend computerized measures of range of motion, which can be done with inclinometers, and where the result is of unclear therapeutic value and citing a lack of extenuating circumstances establishing the medical necessity for specialized testing. The stated purpose of the request for Retrospective review of range of motion testing for the thoracic spine (DOS 03/12/2014) was not noted. The request for Retrospective review of range of motion testing for the thoracic spine (DOS 03/12/2014) was denied on April 8, 2014, noting that referenced guidelines do not recommend computerized measures of range of motion, which can be done with inclinometers, and where the result is of unclear therapeutic value and citing a lack of extenuating circumstances establishing the medical necessity for specialized testing. The stated purpose of the request for Retrospective review of range of motion testing for the left leg (DOS 03/12/2014) was not noted. The request for Retrospective review of range of motion testing for the left leg (DOS 03/12/2014) was denied on April 8, 2014, noting that referenced guidelines do not recommend computerized measures of range of motion, which can be done with inclinometers, and where the result is of unclear therapeutic value and citing a lack of extenuating circumstances establishing the medical necessity for specialized testing. The stated purpose of the request for Retrospective review of range of motion testing for the right leg (DOS

03/12/2014) was not noted. The request for Retrospective review of range of motion testing for the right leg (DOS 03/12/2014) was denied on April 8, 2014, noting that referenced guidelines do not recommend computerized measures of range of motion, which can be done with inclinometers, and where the result is of unclear therapeutic value and citing a lack of extenuating circumstances establishing the medical necessity for specialized testing. Per the report dated March 12, 2014, the treating physician noted complaints of low back pain with radiation to both legs, rated as 9/10. The injured worker continues to work and takes oral medications. Exam findings included lumbar flexion 35 degrees, extension 10 degrees, lateral bending 10 degrees. Per the report dated April 21, 2014, the treating physician noted complaints of low back pain with radiation to both legs, rated as 9/10, as well as increased spasms to both legs. The injured worker is not working. Exam findings included lumbar tenderness and a positive bilateral straight leg raising test.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective review of range of motion testing for the lumbar spine (DOS 03/12/14):

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)- TWC, Low Back Procedure Summary.

MAXIMUS 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), Low Back- Lumbar & Thoracic (Acute & Chronic), Flexibility.

Decision rationale: The requested Retrospective review of range of motion testing for the lumbar spine (DOS 03/12/14), is not medically necessary. Chronic Pain Medical Treatment Guidelines, Functional Improvement Measures, Page 48, note that such measures are recommended. However, Official Disability Guidelines (ODG), Low Back- Lumbar & Thoracic (Acute & Chronic), Flexibility, note that computerized range of motion testing "Not recommended as a primary criteria, 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." and "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." The injured worker has low back pain with radiation to both legs, rated as 9/10, as well as increased spasms to both legs. The treating physician has documented lumbar tenderness and a positive bilateral straight leg raising test, lumbar flexion 35 degrees, extension 10 degrees, lateral bending 10 degrees. The treating physician has not documented exceptional circumstances to establish the medical necessity for this testing as an outlier to referenced guideline negative recommendations. The criteria noted above not having been met, Retrospective review of range of motion testing for the lumbar spine (DOS 03/12/14) is not medically necessary.

Retrospective review of range of motion testing for the thoracic spine (DOS 03/12/2014): 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)- TWC, Low Back Procedure Summary.

MAXIMUS 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), Low Back- Lumbar & Thoracic (Acute & Chronic), Flexibility.

Decision rationale: The requested Retrospective review of range of motion testing for the thoracic spine (DOS 03/12/14), is not medically necessary. Chronic Pain Medical Treatment Guidelines, Functional Improvement Measures, Page 48, note that such measures are recommended. However, Official Disability Guidelines (ODG), Low Back- Lumbar & Thoracic (Acute & Chronic), Flexibility, note that computerized range of motion testing "Not recommended as a primary criteria, 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." and "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." The injured worker has low back pain with radiation to both legs, rated as 9/10, as well as increased spasms to both legs. The treating physician has documented lumbar tenderness and a positive bilateral straight leg raising test, lumbar flexion 35 degrees, extension 10 degrees, lateral bending 10 degrees. The treating physician has not documented exceptional circumstances to establish the medical necessity for this testing as an outlier to referenced guideline negative recommendations. The criteria noted above not having been met, Retrospective review of range of motion testing for the thoracic spine (DOS 03/12/14) is not medically necessary.

Retrospective review of range of motion testing for the left leg (DOS 03/12/2014): 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)- TWC, Low Back Procedure Summary.

MAXIMUS 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), Low Back- Lumbar & Thoracic (Acute & Chronic), Flexibility.

Decision rationale: The requested Retrospective review of range of motion testing for the left leg (DOS 03/12/14), is not medically necessary. Chronic Pain Medical Treatment Guidelines, Functional Improvement Measures, Page 48, note that such measures are recommended. However, Official Disability Guidelines (ODG), Low Back- Lumbar & Thoracic (Acute & Chronic), Flexibility, note that computerized range of motion testing "Not recommended as a primary criteria, 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." and "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." The injured worker has low back pain with radiation to both legs, rated as 9/10, as well as increased spasms to both legs. The treating physician has documented lumbar tenderness and a positive bilateral straight leg raising test, lumbar flexion 35 degrees, extension 10 degrees, lateral bending 10 degrees. The treating physician has not documented exceptional circumstances to establish the medical necessity for this testing as an outlier to referenced guideline negative recommendations. The criteria noted above not having been met. Retrospective review of range of motion testing for the left leg (DOS 03/12/14) is not medically necessary.

Retrospective review of range of motion testing for the right leg (DOS 03/12/2014): 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)- TWC, Low Back Procedure Summary.

MAXIMUS 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), Low Back- Lumbar & Thoracic (Acute & Chronic), Flexibility.

Decision rationale: The requested Retrospective review of range of motion testing for the right leg (DOS 03/12/14), is not medically necessary. Chronic Pain Medical Treatment Guidelines, Functional Improvement Measures, Page 48, note that such measures are recommended. However, Official Disability Guidelines (ODG), Low Back- Lumbar & Thoracic (Acute & Chronic), Flexibility, note that computerized range of motion testing "Not recommended as a primary criteria, 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." and "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." The injured worker has low back pain with radiation to both legs, rated as 9/10, as well as increased spasms to both legs. The treating physician has documented lumbar tenderness and a positive bilateral straight leg raising test, lumbar flexion 35 degrees, extension 10 degrees, lateral bending 10 degrees. The treating physician has not documented exceptional circumstances to establish the medical necessity for this testing as an outlier to referenced guideline negative recommendations. The criteria noted above not having been met, Retrospective review of range of motion testing for right leg (DOS 03/12/14) is not medically necessary.