

<b>Case Number:</b>	CM15-0011109		
<b>Date Assigned:</b>	01/29/2015	<b>Date of Injury:</b>	06/25/2011
<b>Decision Date:</b>	03/30/2015	<b>UR Denial Date:</b>	12/23/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/21/2015

### 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 44-year-old male who reported injury on 06/25/2011. The mechanism of injury was not specified. His diagnoses included left shoulder pain and dysfunction, bursitis, partial thickness rotator cuff tear, AC arthrosis, and left thumb trauma/laceration. Past treatments included medication, surgery and physical therapy. On 11/26/2014, the injured worker complained of intermittent left shoulder pain rated 5/10 with no symptomatic changes. The physical examination of the left shoulder revealed range of motion with flexion at 160 degrees, internal rotation at 70 degrees, external rotation at 80 degrees. The injured worker had a positive impingement test. There was no atrophy seen and sensory and motor were indicated to be intact. Relevant medications were not noted upon examination. The treatment plan included range of motion testing. A rationale was not provided. A Request for Authorization form was submitted on 11/26/2014.

### 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:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Range of motion

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Flexibility

**Decision rationale:** The request for range of motion testing is not medically necessary. According to the Official Disability Guidelines, range of motion is not recommended as a primary criteria, but should be a part of a routine musculoskeletal evaluation. The guidelines also state, relation between lumbar range of motion measures and functional ability is weak or nonexistent. The injured worker was indicated to have active range of motion measurements performed on 11/26/2014. However, there was lack of documentation of a clear rationale to indicate medical necessity for a range of motion test. Based on the above, the request is not supported by the evidence based guidelines. As such, the request is not medically necessary.