

Case Number:	CM15-0037959		
Date Assigned:	04/09/2015	Date of Injury:	11/25/2013
Decision Date:	06/18/2015	UR Denial Date:	02/06/2015
Priority:	Standard	Application Received:	02/27/2015

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: New York

Certification(s)/Specialty: Emergency 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 37-year-old female who has reported the gradual onset of widespread pain and mental illness attributed to usual work activities, with listed injury dates of 07/01/2011- 07/22/2013. Her recent diagnoses include cervical disc herniation, myelopathy, lumbar spondylosis, thoracic spondylosis, chondromalacia patella medial meniscus tears, depression, sleep disorder and headache. A left and right knee MRI on 6/27/14 and 6/30/14 were normal. MRIs of the entire spine were normal. Treatment has included topical and oral medications, physical therapy, chiropractic and acupuncture. The treating physician reports during 2014 to January 2015 reflect ongoing, widespread pain, spasm, tenderness, and a decreased left Achilles reflex. Work status was modified and unchanged during this time period. No reports discussed whether the injured worker had returned to work during this time. There was no discussion of how range of motion was necessary to determine the treatment plan beyond stating that it would help determine functional improvement. Functional capacity evaluations were to help monitor functional improvement as well. The specific components of the functional capacity evaluations were not discussed. None of the reports discussed the results of the functional capacity evaluations and how the results would impact the treatment plan. No reports show a decreasing dependency on medical care. No reports discussed the specific indications for opioids or the results of using tramadol or any other medication. On 1/23/14, the injured worker was seen for an initial visit by the current primary treating physician. There was neck, back, and knee pain. There were no ongoing medications. There was spasm, tenderness, and range of motion limited by pain. There was a right C5 sensory deficit and a decreased left Achilles reflex. The treatment plan included modified work, physical therapy, chiropractic, a MultiStim unit, a lumbar brace, and a psychological consultation. There was no specific

assessment of function beyond references to pain with doing activities of daily living. The injured worker was stated to be not working. On 3/26/14 additional physical therapy and a functional capacity evaluation were prescribed. The injured worker was able to pick up things from the floor better. On 5/21/14 Work Hardening, knee MRIs with 3D, and a functional capacity evaluation were prescribed. On 7/9/14 Work Hardening, topical compounds, and electrodiagnostic testing were prescribed. In the discussion of the specific criteria for Work Hardening, it was noted that there had been no contact with the employer and that any job activities were not confirmed by the employer. On 7/28/14, the injured worker was able to cook. On 9/3/14 acupuncture x 6, topical compounds, a urine drug screen, a functional capacity evaluation, and modified work were prescribed. On 9/25/14, the injured worker was able to cook and walk for 25 minutes. She had completed seven acupuncture visits. On 10/8/14, the injured worker was able to do house chores for one hour. 13 sessions of acupuncture had been completed. On 10/31/14, the injured worker was able to cook, clean, and walk for one hour. Goniometer measurements were given. On 11/10/14, 24 visits of acupuncture were reported to have provided functional improvement consisting of cook and clean the house for one hour, and shop for groceries for 20-30 min. Per the PR2 of 12/17/2014, there was ongoing widespread pain. There was spasm and tenderness. The injured worker was able to walk for up to one hour. Topical compounds, electrodiagnostic testing, and modified work were prescribed. There was no discussion of any medication indications or results of use. The specific indications for electrodiagnostic testing were listed as cervical spondylosis, peripheral neuropathy, and carpal tunnel syndrome. A psychologist evaluated the injured worker on 6/24/14, diagnosed depression and anxiety, and recommended psychotherapy. Subsequent reports during 2014-2015 show ongoing psychotherapy over many months, without specific functional improvement. On 9/3/14, a neurologist evaluated the injured worker. There were no neurological deficits other than slight hypesthesia of the left face. Treatment of headaches was recommended. On 2/6/15, Utilization Review certified 6 visits of acupuncture, a urine drug screen, 6 visits of chiropractic, and a neurology consult. Tramadol was partially certified. 51 other requests were non-certified. The requests were retrospective, with dates of service ranging from February to December 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective EMG of the Bilateral Upper Extremities (DOS: 12/17/14): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 182, 268, 272.

Decision rationale: There are no reports from the prescribing physician, which adequately present the neurologic findings leading to medical necessity for electrodiagnostic testing. Non-specific pain or paresthesias are not an adequate basis for performance of EMG or NCV. Medical necessity for electrodiagnostic testing is established by a clinical presentation with a sufficient degree of neurologic signs and symptoms to warrant such tests. Non-specific, non-dermatomal extremity symptoms are not sufficient alone to justify electrodiagnostic testing. The MTUS, per the citations listed above, outlines specific indications for electrodiagnostic testing, and these indications are based on specific clinical findings. The physician should provide a diagnosis that is likely based on clinical findings, and reasons why the test is needed. The clinical evaluation is minimal and there is no specific neurological information showing the need

for electrodiagnostic testing. For example, a diagnosis of radiculopathy should be supported by the signs and symptoms listed in the MTUS cited above. Based on the clinical information, there are no significant neurologic abnormalities and no specific neurologic symptoms. The diagnoses of cervical spondylosis, peripheral neuropathy, and carpal tunnel syndrome were not adequately supported by the clinical evaluation. Based on the current clinical information, electrodiagnostic testing is not medically necessary, as the treating physician has not provided the specific indications and clinical examination outlined in the MTUS.

Retrospective NCV of the Bilateral Upper Extremities (DOS: 12/17/14): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 182, 268, 272.

Decision rationale: There are no reports from the prescribing physician, which adequately present the neurologic findings leading to medical necessity for electrodiagnostic testing. Non-specific pain or paresthesias are not an adequate basis for performance of EMG or NCV. Medical necessity for electrodiagnostic testing is established by a clinical presentation with a sufficient degree of neurologic signs and symptoms to warrant such tests. Non-specific, non-dermatomal extremity symptoms are not sufficient alone to justify electrodiagnostic testing. The MTUS, per the citations listed above, outlines specific indications for electrodiagnostic testing, and these indications are based on specific clinical findings. The physician should provide a diagnosis that is likely based on clinical findings, and reasons why the test is needed. The clinical evaluation is minimal and there is no specific neurological information showing the need for electrodiagnostic testing. For example, a diagnosis of radiculopathy should be supported by the signs and symptoms listed in the MTUS cited above. Based on the clinical information, there are no significant neurologic abnormalities and no specific neurologic symptoms. The diagnoses of cervical spondylosis, peripheral neuropathy, and carpal tunnel syndrome were not adequately supported by the clinical evaluation. Based on the current clinical information, electrodiagnostic testing is not medically necessary, as the treating physician has not provided the specific indications and clinical examination outlined in the MTUS.

Retrospective Inflammation Topical Compound: Lidocaine 6%, Gabapentin 10%, Ketoprofen 10%, 180gm, with 2 refills (DOS: 12/17/14): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain, Topical Medications Page(s): 60, 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain chapter, Topical analgesics.

Decision rationale: No physician reports discuss the specific indications and medical evidence in support of the topical medications prescribed in this case. The treating physician has not discussed the ingredients of this topical agent and the specific indications for this injured worker. Per the MTUS page 60, medications are to be given individually, one at a time, with assessment of specific benefit for each medication. Provision of multiple medications simultaneously is not recommended. In addition to any other reason for lack of medical

necessity for these topical agents, they are not medically necessary on this basis at minimum. The Official Disability Guidelines state that Custom compounding and dispensing of combinations of medicines that have never been studied is not recommended, as there is no evidence to support their use and there is potential for harm. The compounded topical agent in this case is not supported by good medical evidence and is not medically necessary based on this Official Disability Guidelines recommendation. The MTUS states that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Topical lidocaine, only in the form of the Lidoderm patch, is indicated for neuropathic pain (which is not present in this case). The MTUS states that the only form of topical lidocaine that is recommended is Lidoderm. The topical lidocaine prescribed in this case is not Lidoderm. Per the MTUS citation, there is no good evidence in support of topical gabapentin; this agent is not recommended. Note that topical ketoprofen is not FDA approved, and is not recommended per the MTUS. The topical compounded medication prescribed for this injured worker is not medically necessary based on the MTUS, the Official Disability Guidelines, lack of medical evidence, and lack of FDA approval.

Retrospective Muscular Pain Topical Compound: Flurbiprofen 15%, Cyclobenzaprine 2%, Baclofen 2%, Lidocaine 5%, 180gm, with 2 refills (DOS: 12/17/14): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain, Topical Medications Page(s): 60, 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain chapter, Topical analgesics.

Decision rationale: No physician reports discuss the specific indications and medical evidence in support of the topical medications prescribed in this case. The treating physician has not discussed the ingredients of this topical agent and the specific indications for this injured worker. Per the MTUS page 60, medications are to be given individually, one at a time, with assessment of specific benefit for each medication. Provision of multiple medications simultaneously is not recommended. In addition to any other reason for lack of medical necessity for these topical agents, they are not medically necessary on this basis at minimum. The Official Disability Guidelines state that Custom compounding and dispensing of combinations of medicines that have never been studied is not recommended, as there is no evidence to support their use and there is potential for harm. The compounded topical agent in this case is not supported by good medical evidence and is not medically necessary based on this Official Disability Guidelines recommendation. The MTUS states that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Per the MTUS citation, there is no good evidence in support of topical muscle relaxants; these agents are not recommended. Two muscle relaxants were dispensed simultaneously, which is duplicative, unnecessary, and potentially toxic. Per the MTUS, topical NSAIDs for short-term pain relief may be indicated for pain in the extremities caused by osteoarthritis or tendonitis. There is no good evidence supporting topical NSAIDs for shoulder or axial pain. Two topical NSAIDs were dispensed simultaneously, which is duplicative and unnecessary, as well as possibly toxic. The treating physician did not provide any indications or body part intended for this NSAID. Note that topical flurbiprofen is not FDA approved, and is therefore experimental and cannot be presumed as safe and efficacious. Non-FDA approved medications are not medically necessary. The topical compounded medication prescribed for this injured worker is not medically necessary based on the MTUS, the Official Disability Guidelines, lack of medical evidence, and lack of FDA approval.

Retrospective Range of Motion Measurements and Address ADLs (DOS: 12/17/14): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Definition of Functional Improvement, Functional Improvement Measures Page(s): 1, 48. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back chapter, flexibility. Knee and Hand chapter, computerized testing.

Decision rationale: The MTUS, chronic pain section as cited above, recommends the assessment for functional improvement using a variety of possible measures. Range of motion and assessment of activities of daily living are some of the many possible measures. The assessment of functional improvement, per the MTUS for chronic pain on page 1, is to be performed as part of the history and physical examination, not as a stand-alone procedure. These assessments are routine parts of the usual office visits. At the initial and subsequent visits, the treating physician performed a range of motion test that was possibly different from the usual physical examination. This very possibly was a computerized range of motion test. The request for Independent Medical Review does not define what is meant by range of motion measurement. The ACOEM Guidelines in each of the body part chapters describes the necessary components of the physical examination, and nowhere is a computerized method mentioned or recommended. The Official Disability Guidelines sections cited above note the lack of necessity for any of this kind measurement. Physicians can assess range of motion using the usual, manual and visual techniques that are an integral part of medical practice and which are not separate procedures. The physician is expected to incorporate such measures into the usual office visits and no separate procedures are required, as is noted in the MTUS for assessing functional improvement. None of the physician reports discuss the results of any range of motion measurements, the relevance to this injured workers treatment and functional improvement assessments, and the reasons why it was necessary on a serial basis. As such, the request for separate evaluations of range of motion and activities of daily living during an office visit is not medically necessary.

Retrospective Acupuncture 6 Additional Sessions (DOS: 11/10/14): Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The prescription for additional acupuncture is evaluated in light of the MTUS recommendations for acupuncture, including the definition of functional improvement. On 11/10/14, the injured worker had attended 24 visits of acupuncture over two months. The treating physician did not provide any baseline functional measurements other than the work status. The reported level of function outside of the ongoing limited work status as of 11/10/14 was less than that described in the work status. The reported level of function was fairly minimal and not indicative of a significant increase in function. The reported level of function consisted of 1-1/2 hours of activity per day only. There was no evidence of a reduction in the dependency on continued medical treatment. As a result, the results of acupuncture treatment do not meet the definition of functional improvement as it is defined in the MTUS. The additional acupuncture is not medically necessary.

Retrospective Range of Motion Measurements and Address ADLs (DOS: 11/10/14): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Definition of Functional Improvement, Functional Improvement Measures Page(s): 1, 48. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back chapter, flexibility. Knee and Hand chapter, computerized testing.

Decision rationale: The MTUS, chronic pain section as cited above, recommends the assessment for functional improvement using a variety of possible measures. Range of motion and assessment of activities of daily living are some of the many possible measures. The assessment of functional improvement, per the MTUS for chronic pain on page 1, is to be performed as part of the history and physical examination, not as a stand-alone procedure. These assessments are routine parts of the usual office visits. At the initial and subsequent visits, the treating physician performed a range of motion test that was possibly different from the usual physical examination. This very possibly was a computerized range of motion test. The request for Independent Medical Review does not define what is meant by range of motion measurement. The ACOEM Guidelines in each of the body part chapters describes the necessary components of the physical examination, and nowhere is a computerized method mentioned or recommended. The Official Disability Guidelines sections cited above note the lack of necessity for any of this kind measurement. Physicians can assess range of motion using the usual, manual and visual techniques that are an integral part of medical practice and which are not separate procedures. The physician is expected to incorporate such measures into the usual office visits and no separate procedures are required, as is noted in the MTUS for assessing functional improvement. None of the physician reports discuss the results of any range of motion measurements, the relevance to this injured workers treatment and functional improvement assessments, and the reasons why it was necessary on a serial basis. As such, the request for separate evaluations of range of motion and activities of daily living during an office visit is not medically necessary.

Retrospective Psychological Factor Screening (DOS: 11/10/14): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 100-101.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 391-402, Chronic Pain Treatment Guidelines Behavioral Interventions Page(s): 8-9, 23.

Decision rationale: The primary treating physician reports do not discuss this injured workers specific psychological issues or incorporate any questionnaire results into the treatment plan. The psychological factor screening was performed via a questionnaire that did not appear to play any role in development of the treatment plan. The injured worker was already seeing a psychologist for ongoing therapy. The injured worker had already had a psychological evaluation by a psychologist. The ACOEM Guidelines pages 22-33 and 391-397 discuss the evaluation of patients in general, and of patients with possible "stress-related conditions." Important history and physical findings are outlined. There is practically none of this sort of information in the available reports. The MTUS for chronic pain recommends psychological

evaluation and referral for some patients with chronic pain, and this had already been performed. No screening test is indicated unless it will be used to develop a treatment plan for the injured worker. In this case, the screening test had no apparent role in the treatment plan of the primary treating physician, and there was no apparent change in any treatment plan as a result of the test. The screening was therefore not medically necessary.

Retrospective Range of Motion Measurements and Address ADLs (DOS: 10/31/14): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Definition of Functional Improvement, Functional Improvement Measures Page(s): 1, 48. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back chapter, flexibility. Knee and Hand chapter, computerized testing.

Decision rationale: The MTUS, chronic pain section as cited above, recommends the assessment for functional improvement using a variety of possible measures. Range of motion and assessment of activities of daily living are some of the many possible measures. The assessment of functional improvement, per the MTUS for chronic pain on page 1, is to be performed as part of the history and physical examination, not as a stand-alone procedure. These assessments are routine parts of the usual office visits. At the initial and subsequent visits, the treating physician performed a range of motion test that was possibly different from the usual physical examination. This very possibly was a computerized range of motion test. The request for Independent Medical Review does not define what is meant by range of motion measurement. The ACOEM Guidelines in each of the body part chapters describes the necessary components of the physical examination, and nowhere is a computerized method mentioned or recommended. The Official Disability Guidelines sections cited above note the lack of necessity for any of this kind measurement. Physicians can assess range of motion using the usual, manual and visual techniques that are an integral part of medical practice and which are not separate procedures. The physician is expected to incorporate such measures into the usual office visits and no separate procedures are required, as is noted in the MTUS for assessing functional improvement. None of the physician reports discuss the results of any range of motion measurements, the relevance to this injured workers treatment and functional improvement assessments, and the reasons why it was necessary on a serial basis. As such, the request for separate evaluations of range of motion and activities of daily living during an office visit is not medically necessary.

Retrospective Acupuncture (6-sessions, DOS: 10/31/14): Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The prescription for additional acupuncture is evaluated in light of the MTUS recommendations for acupuncture, including the definition of functional improvement. The treating physician did not provide any baseline functional measurements other than the work status. The reported level of function outside of the ongoing limited work status as of this request was less than that described in the work status (which had not changed). The reported level of function was fairly minimal and not indicative of a significant increase in function. The

reported level of function consisted of 1 hour of light activity per day only. There was no evidence of a reduction in the dependency on continued medical treatment. As a result, the results of acupuncture treatment do not meet the definition of functional improvement as it is defined in the MTUS. The additional acupuncture is not medically necessary.

Retrospective Acupuncture (6-sessions, DOS: 10/08/14): Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The prescription for additional acupuncture is evaluated in light of the MTUS recommendations for acupuncture, including the definition of functional improvement. The treating physician did not provide any baseline functional measurements other than the work status. The reported level of function outside of the ongoing limited work status as of this request was less than that described in the work status (which had not changed). The reported level of function was fairly minimal and not indicative of a significant increase in function. The reported level of function consisted of 1 hour of light activity per day only. There was no evidence of a reduction in the dependency on continued medical treatment. As a result, the results of acupuncture treatment do not meet the definition of functional improvement as it is defined in the MTUS. The additional acupuncture is not medically necessary.

Retrospective Psychological Factor Screening (DOS: 10/08/14): Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 391-402, Chronic Pain Treatment Guidelines Behavioral Interventions Page(s): 8-9, 23.

Decision rationale: The primary treating physician reports do not discuss this injured workers specific psychological issues or incorporate any questionnaire results into the treatment plan. The psychological factor screening was performed via a questionnaire that did not appear to play any role in development of the treatment plan. The injured worker was already seeing a psychologist for ongoing therapy. The injured worker had already had a psychological evaluation by a psychologist. The ACOEM Guidelines pages 22-33 and 391-397 discuss the evaluation of patients in general, and of patients with possible "stress-related conditions". Important history and physical findings are outlined. There is practically none of this sort of information in the available reports. The MTUS for chronic pain recommends psychological evaluation and referral for some patients with chronic pain, and this had already been performed. No screening test is indicated unless it will be used to develop a treatment plan for the injured worker. In this case, the screening test had no apparent role in the treatment plan of the primary treating physician, and there was no apparent change in any treatment plan as a result of the test. The screening was therefore not medically necessary.

Retrospective Range of Motion Measurements and Address ADLs (DOS: 10/08/14): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Definition of Functional Improvement, Functional Improvement Measures Page(s): 1, 48. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back chapter, flexibility. Knee and Hand chapter, computerized testing.

Decision rationale: The MTUS, chronic pain section as cited above, recommends the assessment for functional improvement using a variety of possible measures. Range of motion and assessment of activities of daily living are some of the many possible measures. The assessment of functional improvement, per the MTUS for chronic pain on page 1, is to be performed as part of the history and physical examination, not as a stand-alone procedure. These assessments are routine parts of the usual office visits. At the initial and subsequent visits, the treating physician performed a range of motion test that was possibly different from the usual physical examination. This very possibly was a computerized range of motion test. The request for Independent Medical Review does not define what is meant by range of motion measurement. The ACOEM Guidelines in each of the body part chapters describes the necessary components of the physical examination, and nowhere is a computerized method mentioned or recommended. The Official Disability Guidelines sections cited above note the lack of necessity for any of this kind measurement. Physicians can assess range of motion using the usual, manual and visual techniques that are an integral part of medical practice and which are not separate procedures. The physician is expected to incorporate such measures into the usual office visits and no separate procedures are required, as is noted in the MTUS for assessing functional improvement. None of the physician reports discuss the results of any range of motion measurements, the relevance to this injured workers treatment and functional improvement assessments, and the reasons why it was necessary on a serial basis. As such, the request for separate evaluations of range of motion and activities of daily living during an office visit is not medically necessary.

Retrospective Range of Motion Measurements and Address ADLs (DOS: 09/25/14): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Definition of Functional Improvement, Functional Improvement Measures Page(s): 1, 48. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back chapter, flexibility. Knee and Hand chapter, computerized testing.

Decision rationale: The MTUS, chronic pain section as cited above, recommends the assessment for functional improvement using a variety of possible measures. Range of motion and assessment of activities of daily living are some of the many possible measures. The assessment of functional improvement, per the MTUS for chronic pain on page 1, is to be performed as part of the history and physical examination, not as a stand-alone procedure. These assessments are routine parts of the usual office visits. At the initial and subsequent visits, the treating physician performed a range of motion test that was possibly different from the usual physical examination. This very possibly was a computerized range of motion test. The request for Independent Medical Review does not define what is meant by range of motion measurement. The ACOEM Guidelines in each of the body part chapters describes the necessary components of the physical examination, and nowhere is a computerized method mentioned or recommended. The Official Disability Guidelines sections cited above note the lack of necessity for any of this kind measurement. Physicians can assess range of motion using

the usual, manual and visual techniques that are an integral part of medical practice and which are not separate procedures. The physician is expected to incorporate such measures into the usual office visits and no separate procedures are required, as is noted in the MTUS for assessing functional improvement. None of the physician reports discuss the results of any range of motion measurements, the relevance to this injured workers treatment and functional improvement assessments, and the reasons why it was necessary on a serial basis. As such, the request for separate evaluations of range of motion and activities of daily living during an office visit is not medically necessary.

Retrospective Acupuncture (6-sessions, DOS: 09/25/14): Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The prescription for additional acupuncture is evaluated in light of the MTUS recommendations for acupuncture, including the definition of functional improvement. The treating physician did not provide any baseline functional measurements other than the work status. The reported level of function outside of the ongoing limited work status as of this request was less than that described in the work status (which had not changed). The reported level of function was fairly minimal and not indicative of a significant increase in function. The reported level of function consisted of 1 hour of light activity per day only. There was no evidence of a reduction in the dependency on continued medical treatment. As a result, the results of acupuncture treatment do not meet the definition of functional improvement as it is defined in the MTUS. The additional acupuncture is not medically necessary.