

<b>Case Number:</b>	CM13-0069187		
<b>Date Assigned:</b>	01/17/2014	<b>Date of Injury:</b>	03/19/2013
<b>Decision Date:</b>	06/16/2014	<b>UR Denial Date:</b>	12/16/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/20/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation has a subspecialty in Sports Medicine and is licensed to practice in Texas. 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 physician 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 39-year-old female who reported an injury on 03/19/2013. The mechanism of injury was not stated. Current diagnoses include degenerative changes of the thoracic spine, minimal C5-6 spondylosis, lumbar spine sprain with radiculopathy, cervical spine sprain with radiculopathy, myospasms, gastritis, depression, anxiety, and insomnia. The injured worker was evaluated on 10/07/2013. The injured worker reported persistent upper back and lower back pain. The injured worker reported improvement in symptoms with acupuncture therapy. Physical examination on that date revealed limited cervical range of motion, intact sensation, tenderness to palpation, limited thoracolumbar range of motion with tenderness to palpation, spasm, and positive straight leg raising. Treatment recommendations at that time included a functional restoration program and acupuncture therapy twice per week for 6 weeks.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**SUPERVISED FUNCTIONAL RESTORATION PROGRAM, TWICE A WEEK FOR SIX WEEKS:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines (FUNCTIONAL RESTORATION PROGRAMS), Page(s): 49.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines (FUNCTIONAL RESTORATION PROGRAMS), Page(s): 30-33.

**Decision rationale:** California MTUS Guidelines state functional restoration programs are recommended. An adequate and thorough evaluation should be made, including baseline functional testing. There should be evidence that previous methods of treating chronic pain have been unsuccessful. Treatment is not suggested for longer than 2 weeks without evidence of objective functional improvement. Therefore, the current request for a functional restoration program, twice per week for 6 weeks, cannot be determined as medically appropriate. The injured worker reported improvement in symptoms with acupuncture therapy. There is no evidence of a failure to respond to other appropriate pain modalities with an absence of other options that are likely to result in clinical improvement. The injured worker is also pending a psychological consultation. California MTUS Guidelines state negative predictors of success should be addressed and patients should exhibit motivation to change and willingness to forgo secondary gains. Based on the clinical information received, the request is non-certified.

**ACUPUNCTURE 2 TIMES X 6:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**Decision rationale:** California MTUS Guidelines state acupuncture is used as an option when pain medication is reduced or not tolerated, and may be used as an adjunct to physical rehabilitation and/or surgical intervention. The time to produce functional improvement includes 3 to 6 treatments. Therefore, the current request for 12 sessions of acupuncture exceeds guideline recommendations. There was also no specific body part listed in the current request. As such, the request is non-certified.

**COMPUTERIZED TRACKER RANGE OF MOTION AND MULTIPLE TESTING:**  
Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, LOW BACK, CRITERIA FOR COMPUTERIZED RANGE OF MOTION.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 89-92.

**Decision rationale:** California MTUS/ACOEM Practice Guidelines state a number of functional assessment tools are available, including Functional Capacity Evaluation when re-assessing function and functional recovery. The current request for multiple testing cannot be determined as medically appropriate. The specific type of testing must be listed. The injured worker is also pending physical modalities such as a functional restoration program and a home exercise kit. Therefore, the medical necessity for computerized range of motion testing has not been established. As such, the request is non-certified.