

<b>Case Number:</b>	CM14-0016651		
<b>Date Assigned:</b>	04/11/2014	<b>Date of Injury:</b>	09/13/2012
<b>Decision Date:</b>	05/28/2014	<b>UR Denial Date:</b>	01/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/10/2014

### 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 Occupational 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 expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records: The patient is an employee of [REDACTED] and has submitted a claim for lumbar strain and lumbar disc disease associated with an industrial injury date of 09/13/2012. Treatment to date has included on translaminal lumbar epidural block, left L4-5 on 06/06/2013, physical therapy, acupuncture, and medications. Utilization review from 01/07/2014 denied the requests for range of motion and muscle testing because it is not recommended based on the guidelines; and functional restoration program, 12 visits because the patient to date has not failed all other lower levels of treatment, since his acupuncture treatment is still ongoing. Medical records from 2013 to 2014 were reviewed showing that patient complained of low back pain radiating to the left leg graded 5/10 in severity. Pain was associated with numbness and tingling sensation. Physical examination showed tenderness at paralumbar region. Range of motion of lumbar spine was limited towards flexion at 60 degrees, extension at 20 degrees, lateral bending at 15 degrees on both sides, and rotation at 25 degrees on both sides. Motor testing was 5/5 at bilateral lower extremities. Deep tendon reflexes were equal and symmetric. Sensation was decreased at L4 to S1 dermatomes, left. The sciatic stretch sign was negative. Gait was normal. MRI of the lumbar spine, dated 12/13/2012, was consistent with a broad based disc protrusion with extruded fragment L4-5 with compression of left L5 nerve root.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**RANGE OF MOTION (ROM) TESTING:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Chronic Pain and Official Disability Guidelines (ODG) Lumbar.

**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, Flexibility.

**Decision rationale:** The Expert Reviewer's decision rationale: CA MTUS does not address this topic specifically. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Official Disability Guidelines, (ODG), Low Back, Flexibility was used instead. ODG states that computerized measures of range of motion are not recommended as the results are of unclear therapeutic value. In this case, there is no discussion concerning the need for variance from the guidelines as computerized testing is not recommended. It is unclear why the conventional methods for strength and range of motion testing cannot suffice. Furthermore, the present request does not specify the joint to be tested. Therefore, the request for range of motion (ROM) testing is not medically necessary.

**FUNCTIONAL RESTORATION PROGRAM,12 VISITS:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medical Treatment Guidelines, 9792.24.2 Page(s): 31-32.

**Decision rationale:** The Expert Reviewer's decision rationale: According to pages 31-32 of the California MTUS Chronic Pain Medical Treatment guidelines and ODG pain chapter, functional restoration programs may be considered after an adequate and thorough multidisciplinary evaluation has been made as well as all conservative treatment options have been exhausted and the patient is not a surgical candidate. In this case, there is no evidence that the patient has participated in a multidisciplinary evaluation or has there been discussion concerning surgical ineligibility. In fact, the patient was advised microdiscectomy at L4-5 in a progress report dated 06/25/2013, however, there was no follow-up information regarding surgery. Physical therapy was likewise recommended in January 2013. However, it is unclear if the patient attended therapy sessions or failed a trial of conservative treatment due to lack of documentation. Therefore, the request for functional restoration program, 12 visits is not medically necessary.