

<b>Case Number:</b>	CM14-0021704		
<b>Date Assigned:</b>	05/07/2014	<b>Date of Injury:</b>	04/30/2013
<b>Decision Date:</b>	07/09/2014	<b>UR Denial Date:</b>	02/14/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/20/2014

### 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 Physical Medicine & Rehabilitation and Pain Management has a subspecialty in Interventional Spine 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:

This patient is a 52-year-old male with date of injury 04/30/2013. Per progress report 01/31/2014, the patient presents with upper back, bilateral hands, low back, groin pain. X-ray of the left knee was negative; CT of the C-spine showed disk protrusions at C5 to C7, 9.6-mm air filled cystic lesion in trachea location, spondylosis at C6-C7, and mild facet arthrosis at C5 C6. MRI of the lumbar spine showed multilevel disk protrusions with bilateral foraminal stenosis, posterior annular tear/fissure. Listed diagnoses are status post neck surgery with residuals, lumbar spine strain/sprain, multilevel disk protrusion at lumbar spine, upper and lower extremity neuropathies, left knee sprain/strain, C5 to C7 osteophyte complex, broad-based disk protrusions, and facet arthrosis. Treatment recommendation was for functional restoration program 2 times a week for 6 weeks and also acupuncture 2 times a week for 6 weeks as well as range of motion muscle testing. Pain management consultation was requested for cervical/lumbar spine. The 11/27/2013 report by treating physician has the patient presenting with upper bilateral hand, low back pain at intensity that ranged from 5/10 to 6/10. Request on this visit was for chiropractic treatments and acupuncture 2 x 6 along with other requests. No other prior reports were included, although there are number of reports that postdates the UR decision 02/14/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**RANGE OF MOTION AND MUSCLE TESTING:** 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 Functional improvement measures.

**Decision rationale:** This patient presents with chronic neck, thoracic, and low back pains. The request is for "range of motion and muscle testing." The request appears to be a special kind of range of motion and muscle testing in addition to physical examinations included as part of the ongoing evaluation. While MTUS Guidelines consider "functional improvement measures" important including work function, activities of daily living, self-report of disability, physical impairments such as joint range of motion, muscle flexibility, strength, and endurance deficits, these are included as part of clinical examination findings and MTUS Guidelines recommend range of motion be documented in degrees. It states "include objective measures of clinical exam findings." Range of motion and muscle testing are parts of treating physician's evaluation during follow-up visitations. There is no need for additional specialized range of motion and muscle testing required. Therefore, the request for range of motion and muscle testing is not medically necessary and appropriate.

**ACUPUNCTURE; TWELVE (12) VISITS (2X6):** Upheld

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

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

**Decision rationale:** This patient presents with chronic neck, thoracic, and low back pain. The request is for acupuncture 2 times a week for 6 weeks. MTUS Guidelines recommend initial trial of 3 to 6 sessions and additional sessions if functional improvement is demonstrated. Review of the reports does not show prior acupuncture treatment history and a short-course trial of acupuncture treatments may be reasonable on this patient. However, the request for 12 sessions of acupuncture treatments exceed what is recommended by MTUS Guidelines for initial trial. Therefore, the request for twelve (12) acupuncture visits is not medically necessary and appropriate.