

<b>Case Number:</b>	CM14-0140325		
<b>Date Assigned:</b>	09/10/2014	<b>Date of Injury:</b>	06/22/2012
<b>Decision Date:</b>	10/07/2014	<b>UR Denial Date:</b>	08/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/29/2014

### 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 Pain Management 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 injured worker is a 41-year-old female who sustained an injury to the cervical spine, lumbar spine, coccyx and left shoulder on 6/22/12. The injured worker is status post anterior cervical discectomy and fusion. She complained of left shoulder and neck pain. Magnetic resonance imaging scan of the C spine on 8/14/12 showed disc bulging at the C4-5, C5-6, and C6-7 levels. At the C4-5 level, there was mild right more than left foraminal stenosis. At C5-6 again, there was mild to moderate right more than left neural foraminal stenosis caused by the posterior disc bulge; at the C6-7 level, mild bilateral foraminal stenosis was again noted. Her past surgeries include percutaneous epidural decompression neuroplasty and bilateral medial branch blocks on 11/12/2012 and anterior cervical discectomy and fusion on 4/8/14. Past treatment included ibuprofen 200mg, Motrin 200mg, Tramadol, Norflex, cervical epidural injections with minimal benefit, left wrist support, physical therapy and acupuncture to her neck, left shoulder and lower back for about 6-7 months. Post-operative physical therapy for C spine was approved on 7/23/14. Her diagnoses include cervical radiculopathy; shoulder tendonitis/bursitis; elbow tendonitis/bursitis; wrist tendonitis/bursitis, and lumbosacral radiculopathy. The request for range of motion/computer muscle test per month and work conditioning were denied.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Rom/Computer Muscle Test per month:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES, COMPUTERIZED 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 - Lumbar & Thoracic (Acute & Chronic), Flexibility

**Decision rationale:** Chronic Pain Medical Treatment Guidelines do not discuss the issue and hence the Official Disability Guidelines have been consulted. As per the Official Disability Guidelines, computerized range of motion is not recommended as primary criteria, but should be a part of a routine musculoskeletal evaluation. The guidelines indicate that the examiner should determine range of motion actively and passively as part of the normal exam and an inclinometer is the preferred device for obtaining accurate, reproducible measurements in a simple, practical and inexpensive way per American Medical Association guidelines. In this case, there is no rationale submitted for performing range of motion testing separately by computerized methods. Thus, the request for computerized testing is not medically necessary and appropriate.

**Work Conditioning:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines WORK HARDENING PROGRAM Page(s): 125.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines WORK CONDITIONING, WORK HARDENING Page(s): 125-126.

**Decision rationale:** Per Chronic Pain Medical Treatment Guidelines, treatment is not supported for longer than 1-2 weeks without evidence of injured worker compliance and demonstrated significant gains as documented by subjective and objective gains and measurable improvement in functional abilities. Upon completion of rehabilitation neither program, neither re-enrollment in nor repetition of the same or similar rehabilitation program is medically warranted for the same condition or injury. In this case, the medical records do not document the above criteria being met. The injury is over two years old. There is no evidence of a defined return to work goal. There is no documented specific job to return to with demands exceeding abilities. Therefore, the request is not medically necessary per guidelines.