

<b>Case Number:</b>	CM13-0020411		
<b>Date Assigned:</b>	10/11/2013	<b>Date of Injury:</b>	12/17/2007
<b>Decision Date:</b>	03/17/2014	<b>UR Denial Date:</b>	08/26/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/05/2013

### 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 Family Practice, 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.

### 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 patient is a 52-year-old female who reported an injury on 12/17/07. The injury occurred when the patient was cleaning an oven. Her symptoms include neck pain, upper back pain, low back pain, left shoulder pain, left upper leg pain, and right foot pain. Her physical exam findings include decreased range of motion of the lumbar spine, tenderness to palpation at T2-8 level, and myospasm of the thoracic paraspinal muscles. Her diagnoses include lumbar spine disc bulge with radiculopathy, and thoracic spine segmental dysfunction.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**EMG of the bilateral lower extremities:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

**Decision rationale:** According to ACOEM Guidelines, electromyography may be useful to identify subtle neurological dysfunction in patients with low back symptoms lasting more than 3-4 weeks. More specifically, the Official Disability Guidelines indicate that electromyography is recommended as an option, as it may be useful to obtain unequivocal evidence of radiculopathy after one month of conservative therapy; however, EMG is not necessary if radiculopathy is already clinically obvious. The clinical information provided for review failed to provide

significant objective findings consistent with radiculopathy. Additionally, it is unknown whether the patient has completed an adequate course of conservative treatment at this time. In the absence of this documentation and clinical findings suggestive of radiculopathy, EMG is not supported. As such, the request is non-certified.

**NCS of the bilateral lower extremities:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines

**MAXIMUS guideline:** Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines

**Decision rationale:** According to ACOEM Guidelines, NCS may be useful to identify subtle neurological dysfunction in patients with low back symptoms lasting more than 3 to 4 weeks. More specifically, the Official Disability Guidelines indicate that NCS is not recommended as there is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. The clinical information provided for review failed to provide significant objective findings consistent with radiculopathy. Additionally, it is unknown whether the patient has completed an adequate course of conservative treatment at this time. In the absence of this documentation and clinical findings suggestive of radiculopathy, NCS is not supported. As such, the request is non-certified.

**work/functional capacity evaluation:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Independent Medical Examinations and Consultations (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 7), pages 137-138

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

**Decision rationale:** According to the Official Disability Guidelines, functional capacity evaluations are recommended prior to admission to a work hardening program; however, these evaluations should not be recommended for the sole purpose of determining a workers' effort or compliance if the patient has returned to work and an ergonomic assessment has not been arranged. The clinical information submitted for review failed to provide details regarding the necessity of a functional capacity evaluation at this time. In the absence of specific indications for this type of evaluation, the request is not supported. As such, the request is non-certified.

**physical therapy twice a week for six weeks:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Independent Medical Examinations and Consultations (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 7), pages 137-138

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99.

**Decision rationale:** According to the California MTUS Guidelines, physical therapy is recommended at 8-10 visits over four weeks for treating of neuralgia, neuritis, and radiculitis. However, the request for physical therapy twice a week for six weeks exceeds guideline recommendation of a total of 8-10 visits for the treatment of radiculitis. As the request exceeds the guideline recommendations, it is not supported. As such, the request is non-certified.

**acupuncture once a week for six weeks for the thoracic and lumbar spine:** Upheld

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

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

**Decision rationale:** According to the California MTUS Acupuncture Guidelines, this treatment may be recommended as an option when pain medication is reduced or not tolerated, and when it is used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. Guidelines specify that the time to produce functional improvement is 3-6 treatments. The patient was noted to have functional deficits related to the lumbar spine; however, there were no noted functional deficits on the physical examination related to the thoracic spine. In the absence of measurable functional deficits, acupuncture is not supported to treat the patient's thoracic spine. As such, the request is non-certified.

**urine toxicology screen:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 43, 76, 88, 95.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78.

**Decision rationale:** The patient's medications include Ambien, Hydrocodone, and Soma. According to California MTUS Guidelines, urine drug tests may be recommended with documentation of issues of abuse, addiction, or poor pain control. The clinical information provided for review failed to address whether the patient has had issues with aberrant drug-taking behaviors, abuse, addiction, or poor pain control. In the absence of this documentation, the request for urine drug screen is not supported. As such, the request is non-certified.

**TENS-EMS unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints, Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-116.

**Decision rationale:** According to the California MTUS Guidelines, a TENS unit may be recommended when evidence shows that other appropriate pain modalities have been tried and failed, following a one-month trial period of a TENS unit and documentation of a positive functional response. Continued additional ongoing pain treatment modalities should be documented during the trial period, including medication usage, and the treatment plan should include the specific short-term and long-term goals of the treatment with a TENS unit. The clinical information submitted for review failed to indicate whether the patient had previously undergone a one-month trial period of the TENS unit. Therefore, there was no documentation regarding the patient's outcome on this previous treatment. Moreover, a treatment plan including the specific short-term and long-term goals of treatment was not submitted. Therefore, the patient does not meet the criteria for use of a TENS unit. As such, the request is non-certified.

**lumbar brace:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

**Decision rationale:** According to the ACOEM Guidelines, lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. As the patient's injury was over six years ago, the request for a lumbar support is not supported by guidelines, as she is no longer noted to be in the acute phase. As such, the request is non-certified.

**LINT therapy for the thoracic/lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines, and Aetna's Evidence Based Policies

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-300.

**Decision rationale:** According to the ACOEM Guidelines, physical modalities such as massage, diathermy, cutaneous laser treatment, ultrasound, TENS units, PENS units, and biofeedback have no proven efficacy in treating acute low back symptoms. Guidelines further state that there is insufficient scientific testing to determine the effectiveness of these therapies. The patient was noted to have functional deficits in the lumbar spine, as well as symptoms in his lumbar spine and thoracic spine. However, the ACOEM does not recommend physical modalities, including cutaneous laser treatment; there are no specific recommendations for LINT therapy. As such, the request is non-certified.

**ultrasound, myofascial release, and traction once a week for six weeks for the thoracic/lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173-174.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-300, Chronic Pain Treatment Guidelines Page(s): 60.

**Decision rationale:** According to the ACOEM Guidelines, traction has not been proven effective for lasting relief in treating low back pain and is therefore not recommended. Additionally, physical modalities such as ultrasound are not recommended, as there is insufficient scientific testing to determine the effectiveness. Additionally, the California MTUS Guidelines indicate that massage therapy may be recommended as an adjunct to other recommended treatments. As the details regarding the patient's current conservative treatments were not specifically stated in the medical records and her request for physical therapy was non-certified at this time, the request for massage therapy is also not supported. Furthermore, ultrasound and traction are not recommended by evidence-based guidelines. For these reasons, the requested service is non-certified.