

<b>Case Number:</b>	CM14-0006183		
<b>Date Assigned:</b>	03/03/2014	<b>Date of Injury:</b>	12/13/2012
<b>Decision Date:</b>	07/14/2014	<b>UR Denial Date:</b>	12/30/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/16/2014

### 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 and Rehabilitation 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 patient is a 50-year-old female who has submitted a claim for lumbosacral disc injury, lumbar radiculopathy, lumbosacral sprain/strain injury, and myofascial pain syndrome associated with an industrial injury date of December 13, 2012. Medical records from 2012-2014 were reviewed. The patient complained of persistent low back pain, grade 3-5/10 in severity. The pain radiates to the lower extremities, more on the left. There was numbness sensation on both legs as well. The pain was aggravated by walking, sitting, bending, and twisting activities. Physical examination showed diffuse tenderness over the lumbar paraspinal muscles, facet joints, sacrum, and gluteal region. There was limited range of motion of the lumbosacral spine. Straight leg raise test was positive bilaterally. There were multiple myofascial trigger points in the lumbosacral musculature. Motor strength and sensation was intact. MRI of the lumbar spine showed mild degenerative changes with no significant central spinal canal or neural foraminal stenosis identified. Treatment to date has included medications, physical therapy, chiropractic therapy, home exercise program, activity modification, lumbar epidural steroid injections, TENS, and electro-acupuncture treatment.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**INFRARED, LUMBAR SPINE:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Low Level Laser Therapy Page(s): 57. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Section, Infrared Therapy.

**Decision rationale:** Page 57 of the California MTUS Chronic Pain Medical Treatment Guidelines state that low level laser therapy, therapy that uses near infrared lasers, is not recommended. In addition, Official Disability Guidelines (ODG) states that where deep heating is desirable, providers may consider a limited trial of IR therapy for treatment of acute LBP, but only if used as an adjunct to a program of evidence-based conservative care (exercise). In this case, the patient has chronic low back pain with radiation to the lower extremities. Objective findings include tenderness and limited range of motion. Patient had tried infrared with ice on the lumbar spine on January 2013 but outcome from the treatment was not documented. There was no mention regarding the need for the above request in the medical records submitted. In addition, the exact number of sessions was not specified in the request. Therefore, the request for INFRARED, LUMBAR SPINE is not medically necessary.

**MYOFASCIAL RELEASE, LUMBAR SPINE:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Massage Therapy Page(s): 60.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Massage Therapy Page(s): 60.

**Decision rationale:** As stated on page 60 of the California MTUS Chronic Pain Medical Treatment Guidelines, massage therapy is recommended as an option and as an adjunct to other recommended treatment such as exercise, and should be limited to no more than 4-6 visits. In this case, the patient had physical therapy and it is unclear whether the patient has had prior myofascial release. Although the patient is on a home exercise program, the rationale for myofascial release of the lumbar spine was not documented on the medical records submitted. The medical necessity has not been established. Furthermore, the present request failed to specify the number of sessions of the treatment. Therefore, the request for myofascial release, lumbar spine is not medically necessary.