

<b>Case Number:</b>	CM14-0007894		
<b>Date Assigned:</b>	02/07/2014	<b>Date of Injury:</b>	04/26/2012
<b>Decision Date:</b>	07/02/2014	<b>UR Denial Date:</b>	01/16/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/21/2014

### 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 patient is a 63-year-old female who has submitted a claim for displacement of lumbar intervertebral disc without myelopathy, thoracic or lumbosacral neuritis or radiculitis, unspecified, sprain of lumbosacral (joint) (ligament) and myalgia and myositis, unspecified associated with an industrial injury date of April 26, 2012. The patient complains of increased pain and discomfort involving the low back, with radiation of pain down to the right leg. Physical examination showed tenderness and limitation of motion of the lumbar spine; and diminished sensation and positive seated straight leg raise in the right leg. The diagnoses include lumbosacral disc injury, lumbar spine radiculopathy, lumbar sprain and strain injury, and myofascial pain syndrome. Treatment plan includes a request for electro-acupuncture and infra-red and myofascial release. Treatment to date has included oral analgesics, muscle relaxants, acupuncture, and physical therapy and home exercises. Utilization review from January 16, 2014 denied the requests for electro acupuncture 2 times a week for 4 weeks quantity: 8.00 and infra-red and myofascial release 2 times a week for 4 weeks quantity 8.00. The reason for the denial was because the scope, nature and outcome of prior conservative intervention, including medication management and physical therapy, were not specified in the records.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**ELECTRO ACUPUNCTURE 2 TIMES A WEEK FOR 4 WEEKS QTY:8:** Upheld

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

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

**Decision rationale:** The California Medical Treatment Utilization Schedule (MTUS) Acupuncture Medical Treatment Guidelines recommends acupuncture as an option when pain medication is reduced or not tolerated or as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. Acupuncture can be used to reduce pain, reduce inflammation, and reduce muscle spasms. In this case, there were no VAS scores and physical examination findings showing progression of symptoms. The patient had received an unknown number of acupuncture sessions previously; however, there was no documentation of overall pain improvement and functional gains derived from it. There was also no objective evidence of failure of conservative management to relieve pain. Moreover, it is not clear whether the patient is enrolled in a physical rehabilitation program where acupuncture would be used as an adjunctive treatment. The medical necessity has not been established at this time. Therefore, the request for electro Acupuncture two times a week for four weeks quantity eight is not medically necessary.

**INFRA-RED AND MYOFASCIAL 2X A WEEK FOR 4 WEEKS:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 57.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Low-Level Laser Therapy (LLLT), Massage Therapy Page(s): 60.

**Decision rationale:** Page 57 of the California Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines state that Low-Level Laser Therapy (LLLT) is not recommended. Low-level lasers, also known as "cold lasers" and non-thermal lasers, refer to the use of red-beam or near-infrared lasers. Treatment of most pain syndromes with low level laser therapy provides at best the equivalent of a placebo effect, given the equivocal or negative outcomes from a significant number of randomized clinical trials. On the other hand, page 60 states that 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, there was no clear rationale for the requested treatment. The guideline clearly does not recommend the use of infrared treatment because outcomes were comparable to placebo. There was no compelling rationale concerning the need for variance from the guideline. Moreover, the requested number of visits exceeded the guideline recommendation for myofascial release. Therefore, the request for infra-red and myofascial two times a week for four is not medically necessary.