

<b>Case Number:</b>	CM14-0108438		
<b>Date Assigned:</b>	08/01/2014	<b>Date of Injury:</b>	08/09/2012
<b>Decision Date:</b>	09/16/2014	<b>UR Denial Date:</b>	06/12/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/11/2014

### 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, has a subspecialty in Neuromuscular Medicine and is licensed to practice in Maryland. 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 47 year old male with a work injury dated 8/9/12. The diagnoses include lumbar sprain/strain; thoracic/lumbosacral radiculitis. Under consideration is a request for PT-Mechanical Traction Therapy, Massage Therapy, Ultrasound, Diathermy, Electrical Stimulation, Comp Assist EMS and Matrix x 8, Lumbar. There is a primary treating physician report dated 6/12/14 that states that the patient complains of dull to moderate low back pain with numbness/tingling radiating to the BLE which is aggravated by prolonged sitting, standing, walking and sudden movement. The patient gets relief from medication and rest. On physical exam there is no bruising, swelling, atrophy. There is muscle spasm of the bilateral gluteus and lumbar paravertebral muscles. The sitting straight leg raise is positive. There is a request for PT, Acupuncture, orthopedic consult, and physician consult for medications. The documentation indicates 8 visits of physical therapy ranging from 8/22/13 to 10/14/13. All of the visits rated the patient's pain at 8/10 with no change in range of motion except for one visit on 8/30/13 where the pain was rated a 6/10 and the documentation states that "range of motion is improved."

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy-mechanical traction, massage therapy, ultrasound, diathermy, electrical stimulation, EMS and Matrix #8, lumbar:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine; Massage therapy; therapeutic ultrasound. Decision based on Non-MTUS Citation official Disability Guidelines-TWC, Low Back Procedure (updated 05/12/14), Diathermy.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Neuromuscular electrical stimulation (NMES devices) physical medicine Page(s): 121; 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back-Diathermy Other Medical Treatment Guideline or Medical Evidence.

**Decision rationale:** Physical therapy-mechanical traction, massage therapy, ultrasound, diathermy, electrical stimulation, comp assist EMS and Matrix times 8, lumbar is not medically necessary per the MTUS guidelines. The guidelines indicate that the patient has already had at least 8 visits of PT including electrical stimulation, diathermy, PT, and ultrasound in 2013 with no objective evidence of functional improvement. The MTUS ACOEM guidelines state that physical modalities such as diathermy, units, percutaneous electrical nerve stimulation (PENS) units, and have no proven efficacy in treating acute low back symptoms. The ODG states that diathermy is not recommended because it has no proven efficacy in the treatment of acute low back symptoms. Diathermy is a type of heat treatment using either short wave or microwave energy. It has not been proven to be more effective than placebo diathermy or conventional. Per the guidelines neuromuscular electrical stimulation is used primarily as part of a rehabilitation program following stroke or spinal cord injury and there is no evidence to support its use in chronic pain. The documentation does not indicate that the patient has had a stroke or spinal cord injury. Massage therapy times 8 is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The guidelines state that massage should be limited to 4-6 visits in most cases. Massage is a passive intervention and treatment dependence should be avoided. The documentation indicates that the patient has had prior therapy with massage without evidence of functional improvement. Additionally the request exceeds the guideline recommendations of 4-6 visits. In the presence of no scientific evidence for diathermy and EMS in lumbar pain as well as the fact that prior therapy has not caused evidence of functional improvement the request for physical therapy-mechanical traction, massage therapy, ultrasound, diathermy, electrical stimulation, comp assist EMS and Matrix times 8, lumbar is not medically necessary.