MAXIMUS Federal Services

| Case Number: | CM14-0125940 | | |
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| Date Assigned: | 08/13/2014 | Date of Injury: | 04/29/2014 |
| Decision Date: | 09/11/2014 | UR Denial Date: | 07/07/2014 |
| Priority: | Standard | Application Received: | 08/08/2014 |

## 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 43-year-old male who has submitted a claim for lumbago, status post lumbar spine surgery (2011), lumbar sprain/strain rule out radiculopathy, lumbar spine myospasm, thoracic spine sprain/strain with myospasm, history of hemilaminectomy, and history of thyroid dysfunction associated with an industrial injury date of 04/29/2014.Medical records from 04/30/2014 to 08/13/2014 were reviewed and showed that patient complained of low back pain graded 7/10 with numbness and tingling in the leg and feet, right shoulder pain graded 6/10, right testicular pain graded 6/10, and right buttock pain graded 5/10. The pain was aggravated by physical activities. Physical examination revealed tenderness upon palpation over the lumbar paraspinal muscle and thoracolumbar junction with myospasm. The patient was able to heel and toe walk despite increased pain and difficulty. Miligram's test was positive. Motor strength was 4/5 in right lower extremity. Decreased sensation of the right medial leg was noted. Treatment to date has included at least 4 physical therapy sessions (6 certified visits), 6 sessions of chiropractic therapy, and pain medications.Utilization review dated 07/07/2014 denied the request for acupuncture 2x6 weeks for the lumbar spine because it was reasonable to assess outcome of chiropractic trial first. Utilization review dated 07/07/2014 denied the request for physical therapy 1x6 for lumbar spine because there was no objective evidence of decreased pain levels or functional improvement. Utilization review dated 07/07/2014 denied the request for hot and cold therapy unit rental for 6 weeks because there was no clinical significant benefit over passive methods of delivering cold therapy. Utilization review dated 07/07/2014 denied the request for voltage actuated sensory nerve conduction because its clinical value has not been established in peer-reviewed published medical literature.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Acupuncture 2 Times A Week x 6Weeks for the Lumbar SpineQuantity: 12:** 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 CA MTUS Acupuncture Medical Treatment Guidelines, acupuncture may be used 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. The guidelines allow the use of acupuncture for a frequency and duration of treatment as follows: time to produce functional improvement 3-6 treatments, frequency of 1-3 times per week, and duration of 1-2 months. Additionally, acupuncture treatments may be extended if functional improvement is documented. In this case, there was no documentation of intolerance to pain medications. It is unclear as to whether acupuncture will be used as an adjunct to physical rehabilitation. The medical necessity for acupuncture treatment cannot be established based on the available medical records. Therefore, the request for Acupuncture 2 Times A Week x 6Weeks for the Lumbar Spine Quantity: 12 is not medically necessary and appropriate.

**Physiotherapy 1 Time a Week x 6Weeks for the Lumbar SpineQuantity: 6:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 299. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES: LUMBAR CHAPTER, PHYSICAL / OCCUPATIONAL THERAPYOFFICIAL DISABILITY GUIDELINES: PHYSICAL THERAPY GUIDELINES.

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

**Decision rationale:** According to pages 98-99 of the CA MTUS Chronic Pain Medical Treatment Guidelines, active therapy is recommended for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Physical medicine guidelines allow for fading of treatment frequency from up to 3 visits per week to 1 or less plus active self-directed home physical medicine. In this case, the patient completed at least 4 visits of physical therapy with certification for 6 visits. It is unclear as to why the patient cannot self-transition to HEP. Therefore, the request for Physiotherapy 1 Time a Week x 6Weeks for the Lumbar Spine Quantity: 6 is not medically necessary and appropriate.

**Voltage Acuted Sensory Nerve Conduction (Testing):** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back Chapter, Current Perception, Threshold TestingOther Medical Treatment Guideline or Medical Evidence: Aetna Clinical Policy Bulletin, Quantitative Sensory Testing Methods.

**Decision rationale:** CA MTUS does not specifically address current perception threshold (CPT) testing; however, the Official Disability Guidelines state that CPT testing is not recommended. There are no clinical studies demonstrating that quantitative tests of sensation improve the management and clinical outcomes of patients over standard qualitative methods of sensory testing. Aetna Clinical Policy Bulletin: Quantitative Sensory Testing Methods considers voltage-actuated sensory nerve conduction threshold (VsNCT) testing experimental and investigational because its clinical value has not been established in the peer-reviewed published medical literature. In this case, there was no discussion as to why voltage actuated sensory nerve conduction is needed. There are no clinical studies demonstrating that quantitative tests of sensation improve the management and clinical outcomes of patients over standard qualitative methods of sensory testing; hence, the guidelines do not recommend its use. Therefore, the request for Decision for Voltage actuated Sensory Nerve Conduction (Testing) is not medically necessary and appropriate.

**Hot and Cold Therapy Unit (Rental)Quantity: 6 Weeks Rental:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Aetna Clinical Policy Bulletin: Cryoanalgesia and Therapeutic Cold.

**Decision rationale:** The CA MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, Aetna was used instead. Aetna considers the use of the Hot/Ice Machine and similar devices (e.g., the Hot/Ice Thermal Blanket, the TEC Thermoelectric Cooling System (an iceless cold compression device), the Vital Wear Cold/Hot Wrap, and the Vital Wrap) experimental and investigational for reducing pain and swelling after surgery or injury. Studies in the published literature have been poorly designed and have failed to show that the Hot/Ice Machine offers any benefit over standard cryotherapy with ice bags/packs; and there are no studies evaluating its use as a heat source. In this case, there was no discussion as to why conventional hot/cold pack application will not suffice in symptomatic treatment. The guidelines do not recommend cooling units as it is experimental in reducing pain and swelling. Furthermore, the guidelines are silent on the use of hot therapy units. Therefore, the request for Hot and Cold Therapy Unit (Rental) Quantity: 6 Weeks Rental is not medically necessary and appropriate.