

<b>Case Number:</b>	CM14-0171130		
<b>Date Assigned:</b>	10/23/2014	<b>Date of Injury:</b>	07/03/2012
<b>Decision Date:</b>	12/18/2014	<b>UR Denial Date:</b>	10/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/16/2014

### 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 Wisconsin. 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 injured worker is a 53-year-old male who reported an injury on 07/03/2012. The mechanism of injury was not submitted for clinical review. The diagnoses included lumbosacral sprain/strain, lumbosacral disc injury, lumbosacral radiculopathy, repetitive strain injury, myofascial pain syndrome. The previous treatments included medication, physical therapy, a TENS unit, acupuncture, injections, and a functional restoration program. The diagnostic testing included an Electromyogram (EMG) and Nerve Conduction Velocity (NCV) Studies and a magnetic resonance imaging (MRI). Within the clinical note dated 09/05/2014, it was reported the injured worker complained of low back pain. Upon the physical examination, the provided noted the injured worker to have lumbosacral tenderness to palpation with painful range of motion of the lumbar spine. Deep tendon reflexes were equal bilaterally in the lower extremities. The injured worker had a positive straight leg raise on the left side. A request was submitted for electroacupuncture for the cervical spine. However, a rationale was not submitted for clinical review. The request for authorization was not submitted for clinical review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Electro acupuncture 2x3 for c-spine:** Upheld

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

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

**Decision rationale:** The request for electro acupuncture two times three for cervical spine is not medically necessary. The Acupuncture Medical Treatment Guidelines note acupuncture is used as an option when pain medication is reduced or not tolerated. It may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. Acupuncture can be used to reduce pain, reduce inflammation, increase blood flow, increase range of motion, decrease side effects of medication and induced nausea, promote relaxation in an anxious patient and reduce muscle spasms. The time to produce effect includes 3 to 6 treatments, with a frequency of 1 to 3 times per week. An optimum duration includes 1 to 2 months. Acupuncture treatments may be extended if functional improvement is documented. The clinical documentation submitted failed to indicate the number of sessions of acupuncture the injured worker has utilized. The efficacy of the previous treatment was not submitted for clinical review. Therefore, the request is not medically necessary.

**Infrared heat 2x3 for c-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), Low Back, Infrared Therapy (IR), Neck and Upper Back, Heat/Cold Applications

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Infrared therapy

**Decision rationale:** The request for infrared heat, two times three for the cervical spine, is not medically necessary. The Official Disability Guidelines do not recommend infrared therapy over other heat therapies. Where deep heating is desirable, providers may consider a limited trial of infrared therapy for treatment of acute low back pain, but only if used as an adjunct to a program of evidence based conservative care. There is a lack of significant objective findings warranting the medical necessity for the request. Therefore, the request is not medically necessary.

**Myofascial release 2x3 for c-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:** The request for myofascial release, two times three for the C-spine, is not medically necessary. The California MTUS Guidelines recommend massage therapy limited to 4 to 6 visits in most cases. Massage is beneficial in attenuating diffuse musculoskeletal symptoms, but beneficial effects were registered only during treatment. Massage is a passive intervention and treatment dependence should be avoided. This lack of long term benefit could be due to the short treatment period of treatments such as these do not address any underlying

causes of pain. There is a lack of significant clinical documentation warranting the medical necessity for myofascial release. Additionally, the guidelines note there is no long term effect which would benefit or address any underlying causes of pain. Therefore, the request is not medically necessary.