

<b>Case Number:</b>	CM14-0173356		
<b>Date Assigned:</b>	10/24/2014	<b>Date of Injury:</b>	09/28/2010
<b>Decision Date:</b>	12/04/2014	<b>UR Denial Date:</b>	10/14/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/21/2014

### 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 Preventive Medicine, has a subspecialty in Occupational Medicine and is licensed to practice in Iowa. 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 59 year old patient with date of injury 9/28/10. Medical records indicate the patient is undergoing treatment for lumbar/lumbosacral disc degeneration, lumbago, and difficulty walking. Subjective complaints include pain rated 6/10 with medications. Tenderness over paraspinal muscles more on right side than left, increased pain with flexion and extension, and positive straight leg raise and decreased sensation over right lower leg. Objective findings available for review are limited only to MRI of lumbar spine 8/22/14 which notes minimal bulging of disc margins, thickening of ligamentum flavum and facet arthropathy at L4-5 and L5-S1, and congenitally short pedicles in narrowed anterior/posterior dimension of spinal cord and neural foramen, no neural compromise is noted. Treatment has included a TENS unit and medication (not specified). The utilization review determination was rendered on 10/14/14 recommendation of certification of Massage Therapy x 6- Low back, and non-certification of TENS Unit Belt.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Massage Therapy X6-Low Back:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Massage Therapy.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Massage Therapy Page(s): 60. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Massage Therapy, Manual Therapy

**Decision rationale:** MTUS states regarding massage therapy, "Recommended as an option as indicated below. This treatment should be an adjunct to other recommended treatment (e.g. exercise), and it should be limited to 4-6 visits in most cases." ODG offers additional frequency and timeline for massage therapy by recommending:a. Time to produce effect: 4 to 6 treatments.b. Frequency: 1 to 2 times per week for the first 2 weeks as indicated by the severity of the condition. Treatment may continue at 1 treatment per week for the next 6 weeks.c. Maximum duration: 8 weeks. At week 8, patients should be reevaluated. Care beyond 8 weeks may be indicated for certain chronic pain patients in whom manipulation is helpful in improving function, decreasing pain and improving quality of life.The patient is also starting PT and the request for six visits is with in guideline recommendations. As such, the request for Massage Therapy X6-Low Back is medically necessary.

**TENS Unit Belt:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-315,Chronic Pain Treatment Guidelines Interferential Current Stimulation, Transcutaneous electrotherapy, Page(s): 54, 114-116, 118-12.

**Decision rationale:** ACOEM guidelines state "Insufficient evidence exists to determine the effectiveness of sympathetic therapy, a noninvasive treatment involving electrical stimulation, also known as interferential therapy. At-home local applications of heat or cold are as effective as those performed by therapists." MTUS further states regarding inferential units, "Not recommended as an isolated intervention" and details the criteria for selection:- Pain is ineffectively controlled due to diminished effectiveness of medications; or - Pain is ineffectively controlled with medications due to side effects; or - History of substance abuse; or - Significant pain from postoperative conditions limits the ability to perform exercise programs/ physical therapy treatment; or- Unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.). "If those criteria are met, then a one-month trial may be appropriate to permit the physician and physical medicine provider to study the effects and benefits."The patient is utilizing a TENS unit daily. The treating physician has not provided a medical rationale as to why a TENS belt is needed. TENS supplies should have been provided as part of the original unit. As such, request for TENS Unit Belt is not medically necessary.