

<b>Case Number:</b>	CM14-0177314		
<b>Date Assigned:</b>	10/30/2014	<b>Date of Injury:</b>	07/15/1981
<b>Decision Date:</b>	12/08/2014	<b>UR Denial Date:</b>	10/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/27/2014

### 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:

Injured worker is a 68 year-old male with date of injury 07/15/1981. The medical document associated with the request for authorization, a primary treating physician's progress report, dated 05/15/2014, lists subjective complaints as pain in the low back. MRI of the lumbar spine dated 04/22/2014 was notable for grade one retrolisthesis and mild right neuroforaminal narrowing at L4-5. Injured worker has been receiving spinal decompression therapy and adjunctive rehabilitation physiotherapy modalities and reports to have been progressing well. Objective findings: Examination of the lumbar spine revealed tenderness to palpation from L1 to the sacrum with spasm bilaterally. There was tightness across the lumbar area with area with limited flexion to approximately 45 degrees. Straight leg raise was positive bilaterally at 70 degrees. Injured worker had weakness when toe raise was attempted. Ankle jerk reflexes were absent. Diagnosis: 1. Degenerative disc disease, lumbar spine 2. Peripheral neuropathy 3. Tarsal tunnels syndrome.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Decompression Treatment to Lower Back:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation Page(s): 58.

**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 - Lumbar & Thoracic (Acute & Chronic), Traction

**Decision rationale:** The Official Disability Guidelines do not recommend using powered traction devices, but home-based patient controlled gravity traction may be a noninvasive conservative option, if used as an adjunct to a program of evidence-based conservative care to achieve functional restoration. As a sole treatment, traction has not been proved effective for lasting relief in the treatment of low back pain. The evidence suggests that any form of traction may not be effective. Neither continuous nor intermittent traction by itself was more effective in improving pain, disability or work absence than placebo, sham or other treatments for injured workers with a mixed duration of LBP, with or without sciatica. Decompression treatment to lower back is not medically necessary.

**Electrical Stimulation Lower Back:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrical Nerve Stimulation (TENS) Page(s): 114-11.

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

**Decision rationale:** The Official Disability Guidelines do not recommend neuromuscular electrical stimulation except for spinal cord injured patients. The injured worker does not have spinal cord injury. Electrical stimulation lower back is not medically necessary.

**Laser Treatments to Legs and Feet:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Low Level Laser Therapy (LLLT) Page(s): 57. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment in Workers Compensation (TWC), Low Back Procedure Summary

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

**Decision rationale:** The MTUS states that "Low Level Laser Therapy (LLLT) is not recommended." Despite some positive findings, data is lacking on how LLLT effectiveness is affected by four important factors: wavelength, treatment duration of LLLT, dosage and site of application over nerves instead of joints. There are insufficient data to draw firm conclusions about the effects of LLLT for low-back pain compared to other treatments, different lengths of treatment, different wavelengths and different dosages. Laser Treatments to Legs and Feet is not medically necessary.

**Lower Back Massage:** 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 Page(s): 60.

**Decision rationale:** According to the MTUS, massage therapy can be recommended as an option when limited to 4-6 visits and as an adjunct to other recommended treatments, specifically, an exercise regimen. The benefits of massage therapy at her only during treatment and treatment tendons should be avoided. The short-term benefits of massage therapy or likely due to the fact that massage does not address the underlying causes of pain. There is no documentation that the injured worker is participating in an exercise program as required by the MTUS. The request for Lower Back Massage is not medically necessary.