

<b>Case Number:</b>	CM14-0060090		
<b>Date Assigned:</b>	07/09/2014	<b>Date of Injury:</b>	01/20/2009
<b>Decision Date:</b>	09/09/2014	<b>UR Denial Date:</b>	04/02/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/30/2014

### 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 56-year-old female who has submitted a claim for lumbar disc displacement with myelopathy, cervical disc herniation without myelopathy, tarsal tunnel entrapment of left ankle, and carpal tunnel syndrome (median nerve entrapment at the bilateral wrists) associated with an industrial injury date of 01/20/2009. Medical records from 10/25/2013 to 07/09/2014 were reviewed. It was revealed that the patient complained of severe cervical spine pain aggravated by lying down and constant severe lumbar spine pain with radiation down the bilateral lower extremities. Lumbar spine pain was aggravated by sitting, standing and walking. Physical examination of the cervical spine revealed +4 spasm and tenderness over bilateral paraspinal muscles from C4-7, bilateral suboccipital, and bilateral upper shoulder muscles. Axial compression and distraction tests were positive bilaterally. Bilateral brachioradialis and triceps reflexes were absent. Physical examination of the lumbar spine revealed +4 spasm and tenderness over bilateral lumbar paraspinal muscles from L2 to S1, quadratus lumborum, and multifidus. Kemp's, Braggrad's, Yeoman's and straight leg raise tests were positive bilaterally. Bilateral Achilles reflexes were absent. Sensation to light touch was decreased over left L5 and S1 dermatomal distribution. MRI of the lumbar spine dated 09/23/2013 revealed grade 1 spondylolisthesis with moderate bilateral degenerative facet changes and mild spinal stenosis L4-5, and persistent mild degenerative changes L3-4. Treatment to date has included 10 visits of chiropractic treatment, unspecified visits of physical therapy, and acupuncture. Utilization review dated 04/02/2014 denied the request for electrical muscle stimulation, chiropractic therapy and manipulation to the lumbar and cervical spine #6. The request was denied because the review did not specify the objective outcome of previous chiropractic treatment and physical therapy intervention to substantiate the need for the requests. Utilization review dated

04/02/2014, denied the request for infrared to the cervical, thoracic, and lumbar spine because the objective outcome of prior physical therapy intervention was not specified.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Unattended electrical stimulation to the cervical and lumbar spine #6: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chronic Pain Treatment Guidelines Electrical Muscle Stimulation Page(s): 114-116. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back, Electrical muscle stimulation.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS Page(s): 114-116.

**Decision rationale:** According to CA MTUS Chronic Pain Treatment Guidelines, TENS is not recommended as a primary treatment modality. A trial of one-month home-based TENS may be considered as a noninvasive conservative option. It should be used as an adjunct to a program of evidence-based functional restoration. A one-month trial period of the TENS unit should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function. In this case, it is unclear if the patient is actively participating in a functional restoration program. The guidelines clearly state that TENS is not recommended as a primary treatment modality. Therefore, the request for unattended electrical stimulation to the cervical and lumbar spine #6 is not medically necessary.

#### **Infrared therapy to the cervical and lumbar spine #6: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back, Infrared therapy.

**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:** CA MTUS does not specifically address infrared therapy (IR). Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, Official Disability Guidelines (ODG) was used instead. ODG states that infrared therapy is not recommended over other heat therapies. Where deep heating is desirable, providers may consider a limited trial of IR therapy for treatment of acute low back pain but only as an adjunct to a program of evidence-based conservative care. In this case, it is unclear if the patient is actively participating in a functional restoration program. A trial of IR is only recommended by the guidelines when used as an adjunct to evidence-based conservative care. Moreover, there was no discussion as to why conventional heat therapies will

not suffice in symptomatic treatment. Therefore, the request for Infrared therapy to the cervical and lumbar spine #6 is not medically necessary.

**Chiropractic manipulation therapy to the cervical and lumbar spine #6:**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and upper Back, Manipulation.

**MAXIMUS guideline:** The Expert Reviewer based his/her decision on the MTUS Chronic Pain Medical Treatment Guidelines, Manual Therapy & Manipulation.

**Decision rationale:** According to CA MTUS Chronic Pain Treatment Guidelines, manual therapy, such as chiropractic care, is widely used in the treatment of musculoskeletal pain. The intended goal or effect of Manual Medicine is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. The recommended initial therapeutic care for low back is a trial of 6 visits over 2 weeks, with evidence of objective functional improvement. If chiropractic treatment is going to be effective, there should be some outward sign of subjective or objective improvement within the first 6 visits. Chiropractic care is not recommended for other body parts other than low back. In this case, the patient has already completed 10 visits of chiropractic care without objective evidence of functional improvement, which is necessary to support continuation of treatment. Moreover, the request of chiropractic treatment is only recommended for the low back. Therefore, the request for Chiropractic manipulation therapy to the cervical and lumbar spine #6 is not medically necessary