

<b>Case Number:</b>	CM14-0071969		
<b>Date Assigned:</b>	08/08/2014	<b>Date of Injury:</b>	01/27/2014
<b>Decision Date:</b>	09/11/2014	<b>UR Denial Date:</b>	05/12/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/19/2014

### 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 Anesthesiology, has a subspecialty in Pain 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 injured worker is a 52 year old male who sustained an injury to his low back on 01/27/14. Mechanism of injury was not documented. The one clinical note provided for review dated 04/11/14 reported that the injured worker continued to complain of constant low back pain he described as hot and sore, which he rated 7/10 visual analog scale radiating into the bilateral shoulders, upper back, bilateral lower extremities with associated numbness and tingling. The injured worker stated that his pain was well controlled with medications and that therapy/acupuncture felt decrease the pain temporarily, as he was able to do more activities of daily living. Physical examination noted normal gait; cervical spine tenderness to palpation with spasms of the upper trapezius muscles and sub-occipitals bilaterally; limited range of motion secondary to pain; reflexes equal and symmetrical; sensory intact; strength 2+/5; thoracolumbar spine tenderness to palpation with spasms of the paraspinals and bilateral sacroiliac joints; limited range of motion secondary to pain; positive sitting root test, sensation intact; reflexes equal and symmetrical; strength 2+/5. There were no additional clinical notes provided for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Purchase Of LSO Back Brace:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines Low Back Chapter Back supports.

**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 chapter, Lumbar supports.

**Decision rationale:** The request for purchase of lumbosacral orthosis (LSO) back brace is not medically necessary. There was no evidence that the injured worker had undergone a cervical spine/lumbar spine fusion and there were no additional objective/subjective findings of any instability in the lumbar spine on physical examination. Given this, the request for purchase of LSO back brace is not indicated as medically necessary.

**Acupuncture 2 times a week for six weeks for Lumbar and cervical Spine:** Upheld

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

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

**Decision rationale:** The California Medical Treatment Utilization Schedule (MTUS) recommends three to six treatments to produce functional improvement. Acupuncture treatments may be extended if functional improvement is documented. There was no additional significant clinical information provided for review that would support exceeding the MTUS recommendations, either in frequency or duration of acupuncture therapy treatments. Given this, the request for acupuncture 2 times a week for six weeks for lumbar and cervical spine is not indicated as medically necessary.

**Chiropractic Physiotherapy and Myofascial Release 2 times a week for 6 weeks for Lumbar and Cervical Spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-299, Chronic Pain Treatment Guidelines Page(s): 58. Decision based on Non-MTUS Citation Official Disability Guidelines Neck and Upper Back Chapter.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58-60.

**Decision rationale:** The California Medical Treatment Utilization Schedule recommends up to 18 visits with clinical documentation of objective functional improvement. There were no chiropractic or physical therapy notes provided for review indicating the amount of physical therapy/chiropractic visits that the injured worker had completed to date or the injured worker's response to any previous conservative treatment. Given this, the request for chiropractic physiotherapy and myofascial release 2 times a week for 6 weeks for the lumbar and cervical spine is not indicated as medically necessary.

### **Functional Restoration Program for Lumbar and Cervical Spine: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-299, Chronic Pain Treatment Guidelines Page(s): 58. Decision based on Non-MTUS Citation Official Disability Guidelines Neck/Upper Back.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain programs (functional restoration programs) Page(s): 30-32.

**Decision rationale:** The request for functional restoration program of the lumbar spine and cervical spine is not medically necessary. In addition, there is clinical documentation of previous chiropractic treatment with reported decreased pain and temporary ability to do more activities of daily living. There was no clinical documentation of the exact number of chiropractic visits completed to date. There were no physical therapy notes provided for review indicating the amount of physical therapy visits that the injured worker has completed to date or the injured worker's response to any previous conservative treatment. Furthermore, there was no psychological evaluation provided for review that would indicate the injured worker met the criteria required for enrollment in chronic pain management program. Given this, the request for functional restoration program of the lumbar spine and cervical spine is not indicated as medically necessary.

### **Range of Motion and Muscle testing Lumbar and cervical 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 - Low Back Chapter.

**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 chapter, Flexibility.

**Decision rationale:** The Official Disability Guidelines (ODG) state that treatment with this modality is not recommended as primary criteria, but should be a part of a routine musculoskeletal evaluation. The ODG also states that lumbar range of motion measures and functional ability is weak or non-existent. Value of the sit and reach test is as an indicator of previous back discomfort is questionable. The Official Disability Guidelines does not recommend computerized measures of lumbar spine range of motion which can be done with inclinometers and were the result (range of motion in range of motion) is of unclear therapeutic value. Given this, the request for range of motion and muscle testing for the lumbar and cervical spine is not indicated as medically necessary.

### **Bilateral EMG Lower Extremities: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines - Low Back.

**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 chapter, Electrodiagnostic studies (EDS).

**Decision rationale:** The request for electromyography (EMG) of bilateral lower extremities is not medically necessary. In addition, there is no clinical documentation or rationale for performing nerve conduction studies when an injured worker is presumed to have symptoms on the basis of radiculopathy. Given this, the request for EMG of bilateral lower extremities is not indicated as medically necessary.

**Bilateral NCV Lower Extremities:** 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 Chapter.

**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 chapter, Electrodiagnostic studies (EDS).

**Decision rationale:** The request for nerve conduction velocity (NCV) of bilateral lower extremities is not medically necessary. In addition, there is no clinical documentation or rationale for performing nerve conduction studies when an injured worker is presumed to have symptoms on the basis of radiculopathy. Given this, the request for NCV of bilateral lower extremities is not indicated as medically necessary.

**Pain Management Consult for Lumbar and cervical Spine:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Page 127 and the Official Disability Guidelines E&M Visits.

**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 chapter, Office visits.

**Decision rationale:** The request for pain management consult for the lumbar and cervical spine is not medically necessary. The Official Disability Guidelines states that the need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment; however, given the absence of documentation of conservative treatment, the request for pain management consult for the lumbar and cervical spine is not indicated as medically necessary.

